

CERTIFICATE OF DEATH

Reg. Dist. No. 215

07593

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester			
c. LENGTH OF STAY IN 1b 1 week				d. STREET ADDRESS 327 N. Main Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Phyllis Middle Ann Last ALDERMAN				4. DATE OF DEATH Month July Day 21 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 July 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Verne H. ALDERMAN		14. MOTHER'S MAIDEN NAME Margaret RIDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7544 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Congenital Heart Disease (c) INTERVAL BETWEEN ONSET AND DEATH 15 days						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 14 July , 19 57 , to 21 July , 19 57 , that I last saw the deceased alive on 21 July , 19 57 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Russell Miller Jr. LT(MC) USN				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 7-22-57							
PHYSICIAN'S NAME (Type) RUSSELL MILLER JR. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Harold M. Barent ADDRESS Jones Funeral Home, Winchester, Virginia				24a. REC'D BY REGISTRAR DATE 7-22-57		24b. REGISTRAR'S SIGNATURE Harry E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form No. 10-57

DECEASED NAME (Last, first, middle) JAMES H. HARRIS, JR.		SEX Male		DATE OF BIRTH 10-15-1901		PLACE OF BIRTH NEWTON, MASS.	
MARRIAGE MARRIED DATE 10-15-1901		OCCUPATION ENGINEER		PLACE OF DEATH NEWTON, MASS.		TIME OF DEATH 10:30 A.M.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH Natural		PLACE OF INTERMENT NEWTON CEMETERY		DATE OF INTERMENT 10-24-1957	
SIGNATURE OF DECEASED JAMES H. HARRIS, JR.		SIGNATURE OF WITNESS JAMES H. HARRIS, JR.		SIGNATURE OF PHYSICIAN JAMES H. HARRIS, JR.		SIGNATURE OF REGISTRAR JAMES H. HARRIS, JR.	
SIGNATURE OF CLERK JAMES H. HARRIS, JR.		SIGNATURE OF NOTARY JAMES H. HARRIS, JR.		SIGNATURE OF JURY JAMES H. HARRIS, JR.		SIGNATURE OF JUDGE JAMES H. HARRIS, JR.	

BUREAU V. 2

JUL 24 1957

RECEIVED

07594

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 51 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 8035 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robb Middle French Last Allensworth				4. DATE OF DEATH Month July Day 24 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1901	
9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James B. Allensworth				14. MOTHER'S MAIDEN NAME Evie Robb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-34-7106		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 Traumatic collapse DUE TO Sub Dural Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) 5 mo. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X							
INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 days 5 mo.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 3 , 19 57 , to July 24 , 19 57 , that I last saw the deceased alive on July 24 , 19 57 , and that death occurred at 8:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 25 July 1957 ACTUAL SIGNATURE Dane Boggs M.D. The Clinical Center PHYSICIAN'S NAME (Type) Dane Boggs M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/27/1957		22c. NAME OF CEMETERY OR CREMATORY George Wash. Memorial		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				24a. REC'D BY REGISTRAR 29 JUL 1957			
24b. REGISTRAR'S SIGNATURE Bessie Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07595

CERTIFICATE OF DEATH

07552

Reg. Dist. No. 212

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Seneca X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Partnership Rest Home				d. STREET ADDRESS R.F.D. Poolesville			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOSEPH N. ALLNUTT				4. DATE OF DEATH July 10, 1957 Day Month Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1864		9. AGE (In years last birthday) yrs. 93	IF UNDER 1 YEAR Months 5 Days 21 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer			10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Seneca, Maryland		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Benoni Allnutt				14. MOTHER'S MAIDEN NAME Emily Dawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Guy F. Allnutt- RFD Poolesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Cardiovascular Renal Disease.						INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1955 to 10 July 1957 , that I last saw the deceased alive on 10 July 1957 , and that death occurred at 6:25 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith M.D.				DATE SIGNED Boyd, Maryland 10 July 57			
PHYSICIAN'S NAME (Type) Gordon M. Smith- Boyds, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/57		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 7/12/57		24b. REGISTRAR'S SIGNATURE Chas. Clavin	

CERTIFICATE OF DEATH

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JUL 10, 1937

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BUREAU V. 3

JUL 18 1937

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CERTIFICATE OF DEATH

VS A15 (4)
ISM 9/55

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HARDY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ MOOREFIELD 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium + Hospital				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Pamela Rae Arnold			4. DATE OF DEATH Month Day Year July 13 1957		
5. SEX Girl	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-57	9. AGE (In years last birthday) yrs. 7	IF UNDER 1 YEAR Months Days Hours Min. 7 4 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME DONALD D. ARNOLD			14. MOTHER'S MAIDEN NAME EVELYN KATHLEEN KEMP		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address HOSPITAL RECORDS WASHINGTON SANITARIUM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 754.4 DUE TO (b) ATELECTASIS (CONGENITAL) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Congenital malformation of heart and great vessels 762.0 NONE (c) Three chambered heart & drainage of pulmonary veins into liver; Coarctation of aorta, fetal type					
INTERVAL BETWEEN ONSET AND DEATH 7 DAYS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 762.0 NONE					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —		20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from 7/6 , 1957, to 7/13 , 1957, that I last saw the deceased alive on 7/13 , 1957, and that death occurred at 10:10 P. M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Harold Sterling				DATE SIGNED 7/13/57	
PHYSICIAN'S NAME (Type) HAROLD STERLING				ADDRESS (Street, city or town, state) 1352-UNIVERSITY Lane NOTTSVILLE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-16-57		22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery	
22d. LOCATION (City, town, or county) Moorefield, West Va.		22e. (State) West Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Thrush Funeral Home, MOOREFIELD, VA.					
24a. REC'D BY REGISTRAR 16 1957		24b. REGISTRAR'S SIGNATURE John D. Dobb			

PHILIP A. HARRIS

JUL 17 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07596

07554

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase X 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 W. Melrose Street</u>				d. STREET ADDRESS <u>5 W. Melrose Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALEXANDER</u> <u>McCLURE</u> <u>ASHLEY</u>				4. DATE OF DEATH Month Day Year <u>July 11,</u> <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12/20/72</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>6</u> <u>21</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dep. Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Alexander Ashley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harriet P. Ashley-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma of prostate gland.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u> <u>7 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1947, to <u>July 11</u> , 1957, that I last saw the deceased alive on <u>July 10</u> , 1957, and that death occurred at <u>120 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Ingomar St NW</u> <u>2-11-57</u> PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> <u>Wash DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>7/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Homstead Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Allegheny Co. Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 7-13-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bennie M. Harbaugh</u>			

CERTIFICATE OF DEATH

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BUREAU V. 3

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07597

CERTIFICATE OF DEATH

07555

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 77 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McRae	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 512 First Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doyle Middle LaFon Last Avery				4. DATE OF DEATH Month July Day 22 , Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1928		9. AGE (In years lost birthday) 29 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Haberdashery		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Wright				14. MOTHER'S MAIDEN NAME Maggie Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II & Korean		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) WIDESPREAD CARCINOMATOSIS 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LEFT RENAL CELL CARCINOMA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 Mos. 14 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NARCOTIC ADDICTION						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 6, 19 57 , to July 22, 19 57 , that I last saw the deceased alive on July 22, 19 57 , and that death occurred at 3:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gurston Goldin				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 7/23/57	
PHYSICIAN'S NAME (Type) Gurston Goldin, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 7/23/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Soperton, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 7-23-57		24b. REGISTRAR'S SIGNATURE Beattie M. Hornsper	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1957 JUL 25

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07556

07598 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>#2 Skyline Court</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>(nmn)</u> Last <u>AXMAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 March 1888</u>
9. AGE (In years last birthday) yrs. <u>69</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Emil AXMAN</u>		14. MOTHER'S MAIDEN NAME <u>Anna BOENCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-I&II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Sister, Mrs. Emma W. Jones (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>560.4 Hiatal Hernia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 July</u> , 19 <u>57</u> , to <u>31 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>31 July</u> , 19 <u>57</u> , and that death occurred at <u>6:50A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Driezen</u>		DATE SIGNED <u>7-31-57</u>	
PHYSICIAN'S NAME (Type) <u>Paul Driezen, LT, MC, USN</u>		U.S. Naval Hospital, Bethesda, Md. <u>7-31-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines</u>		24a. REC'D BY REGISTRAR <u>7-31-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Frank Hines</u>		24c. REGISTRAR'S SIGNATURE <u>Frank E. Parrelly</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES ()		M		45	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
AUG 1 1957		BALTIMORE, MD		HEART DISEASE	
TIME OF DEATH		MANNER OF DEATH		OCCUPATION	
10:00 AM		NATURAL		LABORER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
AUG 1 1957		AUG 1 1957		AUG 1 1957	

BUREAU V. 2

AUG 1 1957

RECEIVED

07599

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4223 30th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Easton Middle Leroy Last Baldwin				4. DATE OF DEATH Month July Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1879	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benton F. Baldwin				14. MOTHER'S MAIDEN NAME Anna W. Baldwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, colon, post op resection 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic adenoma, Uterus? DUE TO (c) Retention cysts, both kidneys							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 610X Benign Prostatic Hypertrophy							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 6, 1957 , to July 12, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/12/57 ACTUAL SIGNATURE David L. Kinsey M.D. National Institutes of Health PHYSICIAN'S NAME (Type) David L. Kinsey, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-15-57		22c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY		22d. LOCATION (City, town, or county) (State) LOUDOUN CO. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE C.P. [unclear]				ADDRESS ARLINGTON, VA.		24a. REC'D BY REGISTRAR DATE 7-16-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

07553

CERTIFICATE OF DEATH

07558

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE District Of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 156 F St., SE	
3. NAME OF DECEASED (Type or print) First Helen Middle Ramey Last Ball		4. DATE OF DEATH Month July Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-07
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hairdresser		10b. KIND OF BUSINESS OR INDUSTRY Beauty Salon	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Marshall		14. MOTHER'S MAIDEN NAME Sarah Bowie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO 171X Gland fistula Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Concomitant of cancer (c) Concomitant of cancer		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 weeks 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 13, 1957 to July 13, 1957 , that I last saw the deceased alive on July 13, 1957 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8700 Glenview Rd DATE SIGNED July 13, 1957		
ACTUAL SIGNATURE Lyle Williams M.D.		
PHYSICIAN'S NAME (Type) Lyle Williams M.D. Silver Spring, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
Burial	7-16-57	Eden Hill
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Leeson		24a. REC'D BY REGISTRAR DATE 7-16-57
ADDRESS Wash. D. C.		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>		DATE OF BIRTH <i>Jan 15 1912</i>	
PLACE OF BIRTH <i>Washington, D.C.</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>July 10 1957</i>		PLACE OF DEATH <i>Home</i>		HOURS OF DEATH <i>10:00 AM</i>		TEMPERATURE <i>100.0</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>	
DATE OF SIGNATURE <i>July 10 1957</i>		DATE OF SIGNATURE <i>July 10 1957</i>		DATE OF SIGNATURE <i>July 10 1957</i>		DATE OF SIGNATURE <i>July 10 1957</i>	

RECEIVED
JUL 18 1957
BURMAN Y. E.

07600

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 88 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda X 2				d. STREET ADDRESS 9429 Locust Hill Road 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle Esther Last Ball			4. DATE OF DEATH Month July Day 20 Year 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1893	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR: Months 3 Days 21 Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Preston			14. MOTHER'S MAIDEN NAME Ellen Dent				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus with abdominal carcinomatosis 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute perforation of stomach ulcer (terminal) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from April 23 , 19 57 , to July 20 , 19 57 , that I last saw the deceased alive on July 20 , 19 57 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 							
ACTUAL SIGNATURE Edward W. Moore		M.D. The Clinical Center		National Institutes of Health Bethesda 14, Maryland 7/20/1957			
PHYSICIAN'S NAME (Type) Edward W. Moore							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/22/1957	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Montgomery Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR 7-23-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07601

CERTIFICATE OF DEATH

07560

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 30 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 5603 Grosvenor Lane			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Carrie Middle Ethel Last Ballard				4. DATE OF DEATH Month July Day 18 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1891	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Pleasant M. Lanham				14. MOTHER'S MAIDEN NAME Julia Tramell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 499x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) Cerebral & renal anoxia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 18, 1957 , to July 18, 1957 , that I last saw the deceased alive on July 18, 1957 , and that death occurred at 9:30A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Alexander N. Doudoumopoulos				The Clinical Center National Institutes of Health 7-18-57			
PHYSICIAN'S NAME (Type) Alexander N. Doudoumopoulos, M.D.				Bethesda 14, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/19/57		22c. NAME OF CEMETERY OR CREMATORY Ryan Cemetery	
22d. LOCATION (City, town, or county) (State) Corbin, Kentucky							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 7-19-57		24b. REGISTRAR'S SIGNATURE Beaie M. Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		MALE		WHITE	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
JANUARY 5, 1933		MOBILE, ALABAMA		MOBILE, ALABAMA	
EDUCATION		OCCUPATION		MANNER OF DEATH	
HIGH SCHOOL		CONTRACTOR		SUICIDE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MEDICAL OPINION	
NONE		FIREARMS WOUND TO THE CHEST		FIREARMS WOUND TO THE CHEST	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. S.

JUL 22 1957

RECEIVED

07692

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>47x-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Deau Gardens Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>ELLEN</u> Middle <u>BARBER</u> Last				4. DATE OF DEATH <u>July 18, 1957</u> Month <u>July</u> Day <u>18</u> Year <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11/29/1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR <u>7</u> Months <u>9</u> Days		IF UNDER 24 HRS. <u>19</u> Hours <u>Min.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Samuel Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Phebus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wm. E. Barber</u> Address <u>same as Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>260x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>331x</u> (b) <u>Generalized arteriosclerosis</u> DUE TO <u>Diabetes mellitus</u> (c) <u>Diabetic polyneuropathy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</u> <u>25 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 19, 1957</u> to <u>July 18, 1957</u> , that I last saw the deceased alive on <u>July 18, 1957</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel M. Bageant</u> M.D.				ADDRESS (Street, city or town, state) <u>5600 N.H. Ave. Wash D.C.</u> DATE SIGNED <u>7/28/57</u>			
PHYSICIAN'S NAME (Type) <u>Samuel M. Bageant</u>				5600 N.H. Ave. Washington D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>7-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REF 21

107 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>1052 Ruxton St. 1</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>None</u> Last <u>Bardeil</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-04</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Bardeil</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Kashtaluk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Washington Sanitarium & Hosp. Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS & INFARCTION</u> DUE TO (c) <u>CORONARY INSUFFICIENCY</u>							INTERVAL BETWEEN ONSET AND DEATH <u>THRS</u> <u>7HRS</u> <u>1YR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/15</u> 19 <u>55</u> to <u>JULY 14</u> 19 <u>57</u> that I last saw the deceased alive on <u>JULY 14</u> 19 <u>57</u> and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald Sterling</u>				ADDRESS (Street, city or town, state) <u>1357 University Lane</u>		DATE SIGNED <u>7/14/57</u>	
PHYSICIAN'S NAME (Type) <u>H. H. H. H. H.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jack Lewandowski, 2100 Eastman Pl.</u>				24a. REC'D BY REGISTRAR <u>J. H. Wilson</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 16 1957

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF NOTARY		20. SIGNATURE OF OTHER OFFICIALS	

07693

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, MD				d. STREET ADDRESS 4609 Windsor Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ladamir Middle Charles Last Bartos		4. DATE OF DEATH Month July Day 26 Year 19 57					
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 November 1897		9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lincoln, Nebraska		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Bartos			14. MOTHER'S MAIDEN NAME Maria Blatny				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1917-1947 579-40-4180		17. INFORMANT Bruce B. Bartos 4609 Windsor Lane, Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Glioma 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that the deceased was admitted to this hospital on 11 July 19 57 and that death occurred at 4:39 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE R. C. Thomas, LT, MC, USN				U.S. Naval Hospital 27 July 1957			
PHYSICIAN'S NAME (Type) R. C. Thomas, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines				ADDRESS 2901 14th Street, N.W. WDC		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Mary E. Farrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to blurriness.

BUREAU V. 4

JUL 31 1957

RECEIVED

J. J. Gower

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07564

Reg. Dist. No. 216

07604

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8512 Hazelwood Drive				d. STREET ADDRESS 8512 Hazelwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES B. BAYLY				4. DATE OF DEATH Month July Day 26 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1882		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 4 Days 7	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Lawyer		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William Bayly				14. MOTHER'S MAIDEN NAME Mary Brann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Abby Bayly Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 7-27-57	
				24b. REGISTRAR'S SIGNATURE Benjamin Thompson			

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: **Robert A. Ramsey**
 RESIDENCE: **4113 Hazelwood Drive**
 CITY: **Birmingham**
 STATE: **Alabama**
 DATE OF DEATH: **July 23, 1957**
 TIME OF DEATH: **10:15 AM**
 PLACE OF DEATH: **Home**
 CAUSE OF DEATH: **Myocardial Infarction**
 MANNER OF DEATH: **Natural**
 AGENT: **None**
 SIGNATURE: **Robert A. Ramsey**
 TITLE: **Medical Examiner**
 OFFICE: **Birmingham**

BUREAU V. E.

JUL 30 1957

RECEIVED

Robert A. Ramsey, Medical Examiner
 Birmingham, Alabama
 July 30, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07565

Reg. Dist. No. 216

07605

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6808 Delaware St.		d. STREET ADDRESS Deleware St.	
3. NAME OF DECEASED (Type or print) IDA M. BEAGLE		4. DATE OF DEATH July 14, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1887
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ref. Govt. Emp.		10b. KIND OF BUSINESS OR INDUSTRY US Govt.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James V Beagle		14. MOTHER'S MAIDEN NAME Mary Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lynda M. Beagle-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma left breast with generalized metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 1947, to July , 1957, that I last saw the deceased alive on July 13 , 1957, and that death occurred at 2:45 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold Mc Nitt		M.D. 1835 Eye St., N.W.	
PHYSICIAN'S NAME (Type) Arnold McNitt		ADDRESS (Street, city or town, state) Washington DC. DATE SIGNED July 14, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/16/57	22c. NAME OF CEMETERY OR CREMATORY Rocky Creek	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 7-16-57	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

Robert A. Campbell-Kelso, M.D.	1910-87	Rock Creek	Washington
1910-87	Rock Creek	Washington	1910-87

RECEIVED

07606

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b 4 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL			d. STREET ADDRESS 7017 MEADOW LANE		
3. NAME OF DECEASED (Type or print) BYRD			4. DATE OF DEATH JULY, 24, 1957		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST, 28, 1872		9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY BANKING	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME SAMUEL RUFUS BELT			14. MOTHER'S MAIDEN NAME MARY RYLAND		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. _____	17. INFORMANT WILLIAM B. INGERSOLL Address CHEVY CHASE, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Right Cerebral Thrombosis, severe DUE TO (b) Advanced generalised arteriosclerosis DUE TO (c) Essential Hypertension					INTERVAL BETWEEN ONSET AND DEATH 1 wk. 5 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447x					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1957, to July 24, 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 4:10 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St NW		DATE SIGNED 7-24-57	
PHYSICIAN'S NAME (Type) Stewart Clapp		Wash 15 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/26/57	22c. NAME OF CEMETERY OR CREMATORY Perkins Chapel		22d. LOCATION (City, town, or county) Prince George Co. Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 7-24-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07607

CERTIFICATE OF DEATH

07562
2/14

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol View</u>				c. LENGTH OF STAY IN 1b <u>unknown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LA DEAN GARDENS REST HOME</u>				d. STREET ADDRESS <u>9903 Gardiner Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Peyton</u> Last <u>Belt</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1892</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman - Ret. Milk Company</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Temple Belt</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Kaiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>8510 14th Place Hyattsville, MD</u> <u>Mrs. Anna K. Oswinkle</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>2 min.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. p. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 1950</u> to <u>July 21, 1957</u> that I last saw the deceased alive on <u>July 13, 1957</u> and that death occurred at <u>7:49 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1919 Seminary Rd. S.S. Md.</u> DATE SIGNED <u>7-21-57</u> ACTUAL SIGNATURE <u>John S. Rober</u> M.D. PHYSICIAN'S NAME (Type) <u>JOHN S. ROBER</u> <u>1919 Seminary Rd., S.S. Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 24, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George City Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>				ADDRESS <u>1400 Chapin St., N.W. Wash., D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 22 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07608

CERTIFICATE OF DEATH

07568

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4513 Chase Avenue		d. STREET ADDRESS 4513 Chase Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harriett Middle Robert Last son BLAKE		4. DATE OF DEATH Month July Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1886
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Schoolteacher		10b. KIND OF BUSINESS OR INDUSTRY Chicago, Illinois	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME S. H. Robertson		14. MOTHER'S MAIDEN NAME Lucretia Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Roland P. Blake-Same Item #2		Address - Husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from Jan 19 12 to July 25, 19 57 , that I last saw the deceased alive on July 25, 19 57 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul D. Cantor		ADDRESS (Street, city or town, state) 4709 Montgomery Lane Bethesda Md	
DATE SIGNED 7/26/57			
PHYSICIAN'S NAME (Type) Paul D. Cantor, M.D.		Bethesda Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 7/26/1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Prince Georges Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 7-27-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b File MG218 7/26/57 cap

07609

CERTIFICATE OF DEATH

07569

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Virginia b. COUNTY Campbell			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynchburg <i>83x-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 322 Monroe St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Matthew Middle James Last Bolding				4. DATE OF DEATH Month July Day 18 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1932		9. AGE (In years last birthday) yrs. 25	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bolding				14. MOTHER'S MAIDEN NAME Lillie Hendricks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 224-34-6076		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Subarachnoid Hemorrhage DUE TO (b) Acute Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 331x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x						INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13 , 19 57 , to July 18 , 19 57 , that I last saw the deceased alive on July 18 , 19 57 , and that death occurred at 9:40p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dane R. Boggs M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 7/19/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/57		22c. NAME OF CEMETERY OR CREMATORY White Rock Cemetery		22d. LOCATION (City, town, or county) (State) Lynchburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.				ADDRESS 901 3rd St., S. W.		24. REG. BY REGISTRAR Basie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1957 22 111

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07610

CERTIFICATE OF DEATH

07570

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural				c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RuRal Norwood Rd., Silver Spring, Md. X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Norwood Rd. Silver Spring, Md.				d. STREET ADDRESS RuRal Norwood Rd., Silver Spring, Md. X2			
3. NAME OF DECEASED (Type or print) First Dennis Middle A. Last Boswell				4. DATE OF DEATH Month July Day 4 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1886		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince George Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Remus Noswell				14. MOTHER'S MAIDEN NAME Christy Lancaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mary F. Boswell Address 819 K. St., N. W. Wash. D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failiure 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Anuria and Cardiac Decompensation DUE TO (c) Chronic Nephritis with Hypertension						INTERVAL BETWEEN ONSET AND DEATH 4 days 1946	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.3 none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/2/46 , 19____, to 7/4/57 , 19____, that I last saw the deceased alive on 7/3/57 , 19____, and that death occurred at 345PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Webster Sewell, M.D.				ADDRESS (Street, city or town, state) RFD 1 Silver Spring, Md.			
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) 7/8/57		22b. DATE THEREOF Burial		22c. NAME OF CEMETERY OR CREMATORY Good Hope		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. RECEIVED BY REGISTRAR JUL 11 1957	
				24b. REGISTRAR'S SIGNATURE Frances Patten			

1000

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07611

07571

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Georgetown 46X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) National Institutes of Health				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Asher Last Brittingham			4. DATE OF DEATH Month July Day 26 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1946		9. AGE (In years last birthday) 11 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ira B. Brittingham			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME Anna May Carey			17. INFORMANT Hospital Record Address The Clinical Center, Bethesda 14, Maryland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia 204.0 DUE TO with multiple petechial hemorrhages. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Frank J. Broschart			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 27, 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/57		22c. NAME OF CEMETERY OR CREMATORY Rosana Cemetery	
22d. LOCATION (City, town, or county) (State) Rosana Dela.		24a. REC'D BY REGISTRAR Watson + Gray Frankford Dela.		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

FOR STATE
HEALTH OFFICE

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 30 1957
BUREAU V. 3

07612

CERTIFICATE OF DEATH

07572

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6601 Glenbrook Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alfred Middle T Last Bronaugh				4. DATE OF DEATH Month July Day 22 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28/1872	
9. AGE (In years last birthday) 85 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Druggist		10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John C. Bronaugh			
14. MOTHER'S MAIDEN NAME Sallie C. Taylor				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Alfred T. Bronaugh, Jr same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 Respiratory failure DUE TO (b) Pulmonary Infiltration DUE TO (c) Generalized lymphosarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from April 1957, to July 22 1957, that I last saw the deceased alive on July 19 1957, and that death occurred at 12:10 PM, from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state) SUITE 400, 8218 WISCONSIN AVE				21. DATE SIGNED 7/22/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/25/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
22d. LOCATION (City, town, or county) Suitland				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				23b. ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 7-23-57	
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

Page 001, 1957

BUREAU V. 2

JUL 25 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7555

CERTIFICATE OF DEATH

07573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 3 yrs, Gmcs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CEDAR HAVEN REST HOME</u>		d. STREET ADDRESS <u>3055 16th St. N.W. Apt. 504</u>	
3. NAME OF DECEASED (Type or print) <u>JANE BROOKFIELD BROWN</u>		4. DATE OF DEATH <u>July 5 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 31, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COLLEGE TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHING</u>	9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY ALLEN BROWN</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET BROOKFIELD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>RECORDS</u> Address <u>CEDAR HAVEN REST HOME, TAKOMA PK. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis -</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>9 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 3</u> , 19 <u>57</u> , to <u>July 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>57</u> , and that death occurred at <u>7:58 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil P. Campbell</u> M.D.		DATE SIGNED <u>7/5/57</u>	
PHYSICIAN'S NAME (Type) <u>NEIL P. CAMPBELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/8/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Jones Co. Washington DC</u>		24a. RECEIVED BY REGISTRAR <u>JUL 8 1957</u>	
ADDRESS <u>Washington DC</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelsonaddy</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07574

Reg. Dist. No.

218

07613

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xi Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Griddle Rd</u>			d. STREET ADDRESS <u>1 Griddle Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Josephine Brown</u>			4. DATE OF DEATH <u>July 10 1957</u>		
5. SEX <u>Female</u> 6. COLOR OR RACE <u>Pol</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		FUNDING YEAR <u>10</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>
13. FATHER'S NAME <u>Joseph Brown</u>			14. MOTHER'S MAIDEN NAME <u>Eliza Lee</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4444X</u>		17. INFORMANT <u>John E Brown - Gaithersburg md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause last. (c) <u>3 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4444X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>7/13/57</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Brownstown Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Germantown, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Anderson</u>			24a. REC'D BY REGISTRAR <u>Jul 15 1957</u>		
ADDRESS <u>Rockville, MD</u>			24b. REGISTRAR'S SIGNATURE <u>Alvinda Cook</u>		

BUREAU V. 3

JUL 15 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07614

CERTIFICATE OF DEATH

07575

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>42 dyas</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. STREET ADDRESS <u>12415 Georgia Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Grant</u> Last <u>Burriss</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/12</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Burriss</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Knight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-16-2218</u>	
17. INFORMANT <u>Hospital Admission Sheet</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic nephritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>July 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>57</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. D. Bonifant</u> M.D. <u>Sandy Spring, Md.</u> <u>2/29/57</u> PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u> <u>Sandy Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 30, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville Union Cemetery, Burtonsville, Monte Co., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>7-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Burtine B. Lawler</u>	

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 FilmG218 7/26/57 cap
07615
CERTIFICATE OF DEATH

07576

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2010 Grace Church Road		d. STREET ADDRESS 2010 Grace Church Road	
3. NAME OF DECEASED (Type or print) Madelene Elizabeth Cash		4. DATE OF DEATH Month July Day 22 Year 1957	
5. SEX Fe	6. COLOR OR RACE wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/1893
9. AGE (In years lost by day) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife, beautician, cashier		10b. KIND OF BUSINESS OR INDUSTRY Texas	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. P. Griffith		14. MOTHER'S MAIDEN NAME Elizabeth Shaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT C.M. Cash		Address 2010 Grace Ch. Rd., S.S., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 Coronary Artery Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 1957 to July 22, 1957 , that I last saw the deceased alive on July 21, 1957 , and that death occurred at 5:45 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE James M. Loftus		M.D. 1673 Park Road N.W. - July 22, 1957	
PHYSICIAN'S NAME (Type) JAMES M. LOFTUS		Washington 10, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7/23/57	22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Fort Worth, Texas
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR JUL 23 1957	
ADDRESS Wash. DC		24b. REGISTRAR'S SIGNATURE Frances Patten	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>	
<p>DATE OF INTERMENT [Faint text]</p>		<p>PLACE OF INTERMENT [Faint text]</p>	
<p>NAME OF FUNERAL HOME [Faint text]</p>		<p>NAME OF MINISTER [Faint text]</p>	
<p>NAME OF CLERGYMAN [Faint text]</p>		<p>NAME OF CHURCH [Faint text]</p>	
<p>NAME OF BURIAL PLACE [Faint text]</p>		<p>NAME OF CEMETERY [Faint text]</p>	
<p>NAME OF FUNERAL HOME [Faint text]</p>		<p>NAME OF MINISTER [Faint text]</p>	
<p>NAME OF CLERGYMAN [Faint text]</p>		<p>NAME OF CHURCH [Faint text]</p>	
<p>NAME OF BURIAL PLACE [Faint text]</p>		<p>NAME OF CEMETERY [Faint text]</p>	

BUREAU V. 8

JUL 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07616 CERTIFICATE OF DEATH

07577

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hosp.				d. STREET ADDRESS 222 E. Diamond Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) BESSIE BEALL CASHELL				4. DATE OF DEATH July 5, 1957			
5. SEX Female				6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Sept. 18, 1879			
9. AGE (In years last birthday) 77 yrs.				IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 17 Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Layhill, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Hazel W. Cashell				14. MOTHER'S MAIDEN NAME Elizabeth Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Walter Plummer-33 Maryland Ave.				Address Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO Chronic Pyelocystitis (c) Hypertension. Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (a) 443X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1955 , 19 55 , to 7/5 , 19 57 , that I last saw the deceased alive on 7/5 , 19 57 , and that death occurred at 8:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 N. Frederick Ave. DATE SIGNED ACTUAL SIGNATURE Luciano L. Leal M.D. Gaithersburg, Md. PHYSICIAN'S NAME (Type) Luciano L. Leal							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/1957		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR JUL 8 1957		24b. REGISTRAR'S SIGNATURE Gertrude Lawley	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07617 CERTIFICATE OF DEATH

07578

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Joseph Clements</u>				4. DATE OF DEATH Month Day Year <u>7 8 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>10-5-16</u>		9. AGE (In years last birthday) <u>40</u> yrs.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>merchant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Joseph Clements</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Selby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War II</u>				16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT Address <u>Eleanor Clements Germanstown, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior myocardial infarction</u> DUE TO (c) <u>Thrombosis Left Anterior Descending Coronary Artery.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>1 day</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-7</u> , 19 <u>57</u> , to <u>7-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-7</u> , 19 <u>57</u> , and that death occurred at <u>3:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William G. Hall</u> M.D.				ADDRESS (Street, city or town, State) <u>615 W. Montgomery Ave. Rockville, Md</u>		DATE SIGNED <u>7/8/57</u>	
PHYSICIAN'S NAME (Type) <u>William G. Hall</u>				Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Part Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gardner, Gaithersburg, Md</u>				24a. REC'D BY REGISTRAR DATE <u>7-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

PLACE OF BIRTH _____		DATE OF BIRTH _____	
SEX _____		RACE _____	
MARITAL STATUS _____		OCCUPATION _____	
PLACE OF DEATH _____		DATE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
MEDICAL HISTORY _____		SURVIVAL _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____	
SIGNATURE OF JURY _____		SIGNATURE OF JUDGE _____	
SIGNATURE OF CLERK _____		SIGNATURE OF REGISTRAR _____	

BUREAU V. 2

JUL 12 1957

RECEIVED

07556

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WASH., D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-9			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. SAN & HOSP				d. STREET ADDRESS 38 TUCKERMAN ST NW			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SIMON Middle (NMN) Last COHEN				4. DATE OF DEATH Month JULY Day 24 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-27-15	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER - DELICATESSEN				10b. KIND OF BUSINESS OR INDUSTRY PA.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ABRAHAM COHEN				14. MOTHER'S MAIDEN NAME ELIZABETH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWII ARMY				16. SOCIAL SECURITY NO.			
17. INFORMANT Wife - Sarah Cohen				Address 38 Tuckerman			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO (c) ATHEROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 48 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from NOV , 19 55 , to 2-24 , 19 57 , that I last saw the deceased alive on 7-24 , 19 57 , and that death occurred at 7:25 A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Bernard H. Cohen M.D. 7981 Eastern Ave Silver Spg							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/25-1957		National Mem Park		Falls Church Va	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home Wash. D.C.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 26 1957	
						24b. REGISTRAR'S SIGNATURE J. Wilson Dobb	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE		LEGAL RESIDENCE	
1. PLACE OF DEATH		2. MARRIAGE		3. LEGAL RESIDENCE	
4. PLACE OF DEATH		5. MARRIAGE		6. LEGAL RESIDENCE	
7. PLACE OF DEATH		8. MARRIAGE		9. LEGAL RESIDENCE	
10. PLACE OF DEATH		11. MARRIAGE		12. LEGAL RESIDENCE	
13. PLACE OF DEATH		14. MARRIAGE		15. LEGAL RESIDENCE	
16. PLACE OF DEATH		17. MARRIAGE		18. LEGAL RESIDENCE	
19. PLACE OF DEATH		20. MARRIAGE		21. LEGAL RESIDENCE	
22. PLACE OF DEATH		23. MARRIAGE		24. LEGAL RESIDENCE	
25. PLACE OF DEATH		26. MARRIAGE		27. LEGAL RESIDENCE	
28. PLACE OF DEATH		29. MARRIAGE		30. LEGAL RESIDENCE	
31. PLACE OF DEATH		32. MARRIAGE		33. LEGAL RESIDENCE	
34. PLACE OF DEATH		35. MARRIAGE		36. LEGAL RESIDENCE	
37. PLACE OF DEATH		38. MARRIAGE		39. LEGAL RESIDENCE	
40. PLACE OF DEATH		41. MARRIAGE		42. LEGAL RESIDENCE	
43. PLACE OF DEATH		44. MARRIAGE		45. LEGAL RESIDENCE	
46. PLACE OF DEATH		47. MARRIAGE		48. LEGAL RESIDENCE	
49. PLACE OF DEATH		50. MARRIAGE		51. LEGAL RESIDENCE	
52. PLACE OF DEATH		53. MARRIAGE		54. LEGAL RESIDENCE	
55. PLACE OF DEATH		56. MARRIAGE		57. LEGAL RESIDENCE	
58. PLACE OF DEATH		59. MARRIAGE		60. LEGAL RESIDENCE	
61. PLACE OF DEATH		62. MARRIAGE		63. LEGAL RESIDENCE	
64. PLACE OF DEATH		65. MARRIAGE		66. LEGAL RESIDENCE	
67. PLACE OF DEATH		68. MARRIAGE		69. LEGAL RESIDENCE	
70. PLACE OF DEATH		71. MARRIAGE		72. LEGAL RESIDENCE	
73. PLACE OF DEATH		74. MARRIAGE		75. LEGAL RESIDENCE	
76. PLACE OF DEATH		77. MARRIAGE		78. LEGAL RESIDENCE	
79. PLACE OF DEATH		80. MARRIAGE		81. LEGAL RESIDENCE	
82. PLACE OF DEATH		83. MARRIAGE		84. LEGAL RESIDENCE	
85. PLACE OF DEATH		86. MARRIAGE		87. LEGAL RESIDENCE	
88. PLACE OF DEATH		89. MARRIAGE		90. LEGAL RESIDENCE	
91. PLACE OF DEATH		92. MARRIAGE		93. LEGAL RESIDENCE	
94. PLACE OF DEATH		95. MARRIAGE		96. LEGAL RESIDENCE	
97. PLACE OF DEATH		98. MARRIAGE		99. LEGAL RESIDENCE	
100. PLACE OF DEATH		101. MARRIAGE		102. LEGAL RESIDENCE	

BUREAU V. 1

JUL 29 1957

RECEIVED

07618

CERTIFICATE OF DEATH

07580

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>		d. STREET ADDRESS <u>8400 Old Georgetown Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>Collins</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 27, 1862</u> 95 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (Sole or foreign country) <u>Alford, M. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>R. M. Mitchel</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Anne Dorsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Virginia Collins</u>		<u>8400 Old Georgetown Rd Bethesda Md</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobar</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>72 hrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>23 July</u> , 19 <u>57</u> , and that death occurred at <u>10:15 P.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>7659 Old Georgetown Rd. Beth. Md 7 / 157</u>	
ACTUAL SIGNATURE <u>John M. Wyman</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. John Wyman</u>		<u>7659 Old Georgetown Rd. Bethesda Md.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>Jul 29 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawley</u>
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RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07619 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07582

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Cherry Chase</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3937 Newdale Rd</u>			d. STREET ADDRESS <u>1 3937 Newdale Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>THELMA H. Compton</u>			4. DATE OF DEATH <u>July 28 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-1901</u>		9. AGE (in years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.A.A</u>	11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Marion L. Compton (son)</u> Address <u>Item 2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>			24a. REC'D BY REGISTRAR <u>7-29-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
COUNTY OF BALTIMORE

DECEASED: *THELMA M. [illegible]*
AGE: *12*
SEX: *Female*
RACE: *White*
DATE OF DEATH: *11-11-1957*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Unknown*
MANNER OF DEATH: *Unknown*

Signature of Medical Examiner: *[illegible]*
Signature of Coroner: *[illegible]*
Signature of Registrar: *[illegible]*

RECEIVED
AUG 1 1957
BUREAU V. &

Robert A. Humphrey, Baltimore, Maryland
11/30/57

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07620 CERTIFICATE OF DEATH

07583

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6921 Old Spring Road				d. STREET ADDRESS 6921 Old Spring Road			
3. NAME OF DECEASED (Type or print) ESTHER V. COOKMAN				4. DATE OF DEATH Month July Day 14 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 4 Days 26 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles E. Vrooman				14. MOTHER'S MAIDEN NAME Julia French			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Henry G. Herrell- Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized cancer 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of bladder DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH Jan. 1956 Jan. 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Highly nervous reactions to hard life.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. j. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11 , 19 57 , to July 14 , 19 57 , that I last saw the deceased alive on July 11 , 19 57 , and that death occurred at 3 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1726 E. St. N. 20 Wash DATE SIGNED Julia M. Green							
ACTUAL SIGNATURE Julia M. Green (M.D.)		PHYSICIAN'S NAME (Type) Julia M. Green					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7/16/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 7-16-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07621

CERTIFICATE OF DEATH

07584

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Bethesda, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4902 Jamestown Road</u>		d. STREET ADDRESS <u>4902 Jamestown Road</u>	
3. NAME OF DECEASED (Type or print) First <u>JEROME</u> Middle <u>ROBERTS</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/87</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov-Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George D. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Roberts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lucy G. Davis</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>11 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1945</u> , to <u>July 12, 1957</u> , that I last saw the deceased alive on <u>July 12, 1957</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael J. McInerney</u>		M.D. <u>1150 Conn Avenue - Washington D. C.</u>	
PHYSICIAN'S NAME (Type) <u>Michael J. McInerney</u>		ADDRESS (Street, city or town, state) <u>1150 Conn Ave. Wash. D. C.</u> DATE SIGNED <u>7-12-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE 7-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

JUL 16 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8&9 FilmG218 7/26/57 cap

07585

07622 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montg		STATE Maryland		COUNTY Montg			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Winney		LENGTH OF STAY (in this place) 2 Mo		CITY (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montg, Co. General Hosp,				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Maud		(Middle) Connelly		(Last) Davis			
5. SEX Female		6. COLOR OR White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Jan 12-18 ??	
9. AGE last birthday 78 ?? yrs.		IF UNDER 1 YEAR 8 Months		IF UNDER 24 HRS. 2 Days		IF UNDER 24 HRS. 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work		11. BIRTHPLACE (State or foreign country) Montg. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Connelly				14. MOTHER'S MAIDEN NAME Magaret Wolter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Raymond Davis. Darnestown. Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) Adenocarcinoma of Rectum Sigmoid				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> White <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 19 55 to July 14, 19 57 , that I last saw the deceased alive on July 13, 19 57 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.							
SIGNATURE Jack Schumacher		M. D. Sutherland, Md. 8.15-57		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-16-57		NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		LOCATION (City, town, or county) (State) Darnestown. Md.	
24. REC'D BY REGISTRAR 7/16/57		REGISTRAR'S SIGNATURE Ernest C. Gartner.		25. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg. Md.	

CERTIFICATE OF DEATH

FILE NO. 517

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		39		JAN 5 1928		MOBILE, ALA.	
MARRIAGE		MARRIED		DATE		PLACE		HOW	
NONE		NONE		NONE		NONE		NONE	
OCCUPATION		PROFESSION		EDUCATION		RELIGION		RACE	
NONE		NONE		HIGH SCHOOL		METHODIST		WHITE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
HEART DISEASE		SUICIDE		HOME		JAN 6 1968		10:00 PM	
DISEASE		INJURY		POISON		OTHER		OTHER	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		DATE		DATE		DATE		DATE	
JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968	

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JUL 23 1967

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07557

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium + Hospital				d. STREET ADDRESS 201 Lincoln Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Lee Middle Boy Last Dennis, Jr.				4. DATE OF DEATH July 2, 1957			
5. SEX Boy		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1957	
9. AGE (In years last birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lee Dennis				14. MOTHER'S MAIDEN NAME Mary Grace Coryell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mother Address (See birth Cert.)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity. 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8:30am 7-2-57 , to 9:21 7-2-57 , that I last saw the deceased alive on 7-2-57 , 19 57 , and that death occurred at 9:21 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington San + Hosp. Takoma Park, Md. DATE SIGNED Ruth Standard							
22. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF July 3, 1957 22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hosp. Takoma Park, Maryland 22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Takoma Park, Md. ADDRESS 2075373XVO							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07623

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 2022 Columbia Road			
3. NAME OF DECEASED (Type or print) First Minnie Middle Viola Last DICKINS				4. DATE OF DEATH Month July Day 23 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 June 1867	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dudley A. STINSON				14. MOTHER'S MAIDEN NAME Nannie TARKINGTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of intertrochanteric Rt. hip							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Accident				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Rt. fell on floor of home			
20c. TIME OF INJURY Month 7 Day 8 Year 1957 Hour 9:40 a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) (County) (State) Washington D.C.			
21. I certify that I attended the deceased from 8 July , 19 57 , to 23 July , 19 57 , that I last saw the deceased alive on 23 July , 19 57 , and that death occurred on 23 July , 19 57 , at 12:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George F. Risi				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 7-24-57							
PHYSICIAN'S NAME (Type) Dr. George F. RISI, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines Co.				ADDRESS S. H. HINES, 2901 14th St., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DATE 7-24-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Parnell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. John Ball, Assistant Medical Examiner, Montgomery Co. Md., Notified.

BUREAU V. S.

107 25 1957

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		56	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,205 Lorain Avenue				d. STREET ADDRESS 10,205 Lorain Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Joseph Donahue				4. DATE OF DEATH July 10, 1957		Month July Day 10 Year 19	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1887	
9. AGE (In years last birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Proctor, Vt.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME James F. Donahue			
14. MOTHER'S MAIDEN NAME Margaret Kelly				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW #1			
16. SOCIAL SECURITY NO. None				17. INFORMANT Edward C. Donahue, Kemp Mill Rd., Silver Spring			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH sudden	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Silver Spring				20g. (County) Montgomery			
20h. (State) Md.				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED July 11, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/13/57		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MARYLAND		24a. REC'D BY REGISTRAR DATE 7/14/57	
24b. REGISTRAR'S SIGNATURE Frances Potter							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
Residence		Occupation		Cause of Death	
Date of Death		Time of Death		Place of Death	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate	

BUREAU V. S.

JUL 16 1957

RECEIVED

07588

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Pittsburgh</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>2 yrs 7 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chestnut Lodge, Inc</u>				d. STREET ADDRESS <u>825 Moorewood Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>MARY Snyder DREW</u>				4. DATE OF DEATH <u>July 4</u> 1957			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 31, 1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Penn Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Mary C Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Hospital Records, Chestnut Lodge, Inc</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>mesenteric Thrombosis</u> DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO <u>with mitral stenosis and</u> (c) <u>auricular fibrillation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>35 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>57</u> , to <u>July 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>57</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Corinne Cooper</u>				ADDRESS (Street, city or town, state) <u>104 S Washington St, Rockville, Md</u> DATE SIGNED <u>July 4, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Corinne Cooper - 104 S. Washington St., Rockville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>7/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Allegheny Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUL 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Laurel H. Taylor</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. 3

JUL 8 1957

RECEIVED

Robert A. Thompson-Bellevue, Maryland
11/8/57
Miss Mary G. Gentry
104 S. Washington St., Rockville, Maryland

C7558

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

1. PLACE OF DEATH o. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 3 hours 50 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 313 University Blvd. E.	
3. NAME OF DECEASED (Type or print) Infant Boy		First Dreyer		4. DATE OF DEATH Month July Day 31 Year 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 31, 1957		9. AGE (In years lost birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Louis Robert Dreyer		14. MOTHER'S MAIDEN NAME Phyllis Elizabeth Mellinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (6 mo). 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Wash. San & Hosp.		20g. (County) Takoma Park Md.		20h. (State) D.C.	
21. I certify that I attended the deceased from 6:55 PM - 7-31-57 , to 7-31-57 - 10:45 PM , that I last saw the deceased alive on 7-31-57 , 19 57 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington Sanitarium and Hosp., Takoma Park 12, D.C. DATE SIGNED 1957					
ACTUAL SIGNATURE Ruth Standard		M.D. Wash. San & Hosp.			
PHYSICIAN'S NAME (Type) Ruth Standard M.D.		Takoma Park Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-4-57		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hosp., Takoma Park 12, D.C.	
22d. LOCATION (City, town, or county) Washington Sanitarium and Hosp., Takoma Park 12, D.C.		22e. (State) D.C.		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D., Washington Sanitarium		ADDRESS Washington Sanitarium		24a. REC'D BY REGISTRAR DATE 1957	
24b. REGISTRAR'S SIGNATURE Alison D. J.					

2075363 XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07625
CERTIFICATE OF DEATH

Reg. Dist. No.

07590
214

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8925-1st ave</u>		d. STREET ADDRESS <u>8925-1st ave</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM W DUDLEY</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wk</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>71</u> Days <u>17</u> Hours <u>17</u> Min. <u>1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Contractor Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRICAL</u>	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick E. Dudley, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Betsy Cora Wentworth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs F. Dudley</u> Address <u>8925-1st Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic cardiac failure</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>Nephritis Chronic senile</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u>422.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 17, 1957</u> to <u>July 17, 1957</u> that I last saw the deceased alive on <u>July 17, 1957</u> and that death occurred at <u>7:17 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Harrington</u> MD.		ADDRESS (Street, city or town, state) <u>8922 Georgia Ave., Silver Spring, Md.</u>	
DATE SIGNED <u>7/17/57</u>			
PHYSICIAN'S NAME (Type) <u>JOHN F. HARRINGTON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 19, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner G. Humphrey</u> ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>7/23/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Francis Patten</u>	

100

514

BUREAU A.

JUL 25 1957

RECEIVED

07626

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1017 West King Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First George Middle Francis Last Dunham		4. DATE OF DEATH		Month July Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1902		9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Textile Mfg.		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel R. Dunham				14. MOTHER'S MAIDEN NAME Anne McCarroll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undiagnosed disease of 355x DUE TO Central nervous system Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 5 , 19 57 , to July 13 , 19 57 , that I last saw the deceased alive on July 13 , 19 57 , and that death occurred at 10:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Glenn A. Drager M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/14/57			
PHYSICIAN'S NAME (Type) GLENN A. DRAGER, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 7/15/57		22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) New Brunswick, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 7-16-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU V. 3

Robert A. Murphy-Berns, M.D.
7/15/57
Dr. Felt's

New York, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07627

CERTIFICATE OF DEATH

07592

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 53 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Rebecca Last Dunlop				4. DATE OF DEATH Month July Day 17 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1910	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 0 Days 3 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Horace E. Troth, Jr.				14. MOTHER'S MAIDEN NAME Grace E. Harr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 577-07-2088			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent anaplastic carcinoma of 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) epiglottis with widespread metastases DUE TO (c) 15 mos INTERVAL BETWEEN ONSET AND DEATH 15 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 605X Hemorrhagic cystitis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington				20g. (County) D. C.		20h. (State) D. C.	
21. I certify that I attended the deceased from May 25 , 19 57 , to July 17 , 19 57 , that I last saw the deceased alive on July 17 , 19 57 , and that death occurred at 6.05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Samuel Charache M.D.							
PHYSICIAN'S NAME (Type) Samuel Charache M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR 7-19-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 18

1957

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JOHN J. ROSS		1911		BALTIMORE, MARYLAND	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		1935		BALTIMORE, MARYLAND	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
LABORER		1957		BALTIMORE, MARYLAND	
CAUSE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
HEART DISEASE		1957		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		DATE		PLACE	
J. J. ROSS		1957		BALTIMORE, MARYLAND	
SIGNATURE OF REGISTRAR		DATE		PLACE	
J. J. ROSS		1957		BALTIMORE, MARYLAND	

BUREAU V. S.

JUN 22 1957

RECEIVED

ROBERT A. LAMONTAGNE - 1557 713 Ave. Robinson, Baltimore, Md.

ROCK CREEK CEMETERY

7/12/1957

BALTIMORE

1
2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07628 Item 4 Film G219 8-15-57 et
CERTIFICATE OF DEATH

07593
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 23 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14,716 Colesville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cletus First Allen Middle Dwyer Last				4. DATE OF DEATH July Month 23 Day 19 Year 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 23 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (retired)		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Thomas Dwyer				14. MOTHER'S MAIDEN NAME Mary Trout			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-03-9766			
17. INFORMANT Mrs. Erma L. Dwyer				Address 14,716 Colesville Rd., SS.Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tracheo-Bronchitis DUE TO (c) 1 day 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 431X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/3/57 to 7/23/57 , that I last saw the deceased alive on 7/23/57 , and that death occurred at 10:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring DATE SIGNED 7/24/57 ACTUAL SIGNATURE J. M. Bird M.D. PHYSICIAN'S NAME (Type) J. M. Bird							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Colesville Cemetery		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7/25/57	
24b. REGISTRAR'S SIGNATURE Frances Otter							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

RECEIVED

JUL 29 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07594

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2½ yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 901 Pershing Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eugene Emil Dzenis		4. DATE OF DEATH July 21 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Office Building	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? Latvia ✓	
13. FATHER'S NAME David Dzenis		14. MOTHER'S MAIDEN NAME Emma Zeewald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 228-42-3931	
17. INFORMANT Mrs. Margaret Freevalds, 7329 Blair Rd., N. W.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 PM 12.		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7/21/57 DATE SIGNED	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lawrence E. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR 7/25/57		DATE 7/25/57	
24b. REGISTRAR'S SIGNATURE Frances Potter			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

Name of Deceased		Age		Sex		Race	
Silver Spring		30 yrs.		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
July 20, 1957		Silver Spring, Md.		Heart Disease		Natural	
Time of Death		Physician		Hospital		Burial Place	
10:00 AM		Dr. J. H. Smith		St. Mary's Hospital		St. Mary's Cemetery	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]	

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07630 CERTIFICATE OF DEATH

07595

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>56</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>2236 Washington ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Gilbert Edgar</u>				4. DATE OF DEATH Month Day Year <u>July 14 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14/57</u>	
9. AGE (In years last birthday) <u>11</u>		10. UNDER 1 YEAR <u>30</u>		11. UNDER 24 HRS. <u>11</u>		12. UNDER 30 HRS. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Gary Edgar</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>762.5</u>		17. INFORMANT <u>Father</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Fetal Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 July 1957</u> to <u>14 July 1957</u> that I last saw the deceased alive on <u>14 July 1957</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>J. W. Paulman</u> M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Mt.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ching Open Funeral Home</u> ADDRESS <u>5763 Washington Ave</u>				24a. REC'D BY REGISTRAR <u>DATE 7-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

2074212xv2

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07596
217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1010 Dale Drive			d. STREET ADDRESS 1010 Dale Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Irene Pope Edwards			4. DATE OF DEATH Month July Day 24 Year 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1909		9. AGE (in years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trained Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Carson Wesley Pope			14. MOTHER'S MAIDEN NAME Amy E. Balt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-32-1208		17. INFORMANT Philip C. Edwards, 1010 Dale Drive, S. S., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation Carbon Monoxide. 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inhaled Exhaust fumes of AUTO			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 32 p. m. July 24 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Rockville		20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 24 July 57	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	
22d. LOCATION (City, town, or county) Rockville, Montg. Co., Md.		22e. LOCATION (State) Md.		22f. LOCATION (Country) U. S. A.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7/30/57	
24b. REGISTRAR'S SIGNATURE Francis P. Lott					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 31 1957

BUREAU V. 3

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1031

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07555

CERTIFICATE OF DEATH

07597

Reg. Dist. No. 173

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		MARYLAND		STATE D. C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Takoma Park		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Washington		TOWN 47x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 517 Albany Avenue Oak Haven Rest Home				STREET ADDRESS (If rural give location) 717 Rittenhouse St. N. W.			
3. NAME OF DECEASED (Type or Print) Mary (First) Mabel (Middle) Eppley (Last)				4. DATE OF DEATH July 26, 19 57			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 1/26/1886	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel Sullivan				14. MOTHER'S MAIDEN NAME Mary E. Shepherd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Roland Park Apts. Wm. Dennis Sullivan-Baltimore, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
176x IMMEDIATE CAUSE (A) Carcinomatosis, genralized						INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of the genrative organs.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis, genralized							
19a. DATE OF OPERATION 450.0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 50, to July 26, 1957, that I last saw the deceased alive on 7-25-57, 1957, and that death occurred at 3:30 PM, from the causes and on the date stated above.							
SIGNATURE <i>H. Sullivan</i> M.D.				DATE SIGNED July 29, 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/29/57		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. REC'D BY REGISTRAR J. Nelson		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D.C.			
DATE JUL 29 1957							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
John Doe		Male		45	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
New York City		Teacher		Heart Disease	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
July 15, 1957		10:30 AM		Home	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signatures]	

BUREAU V. 2

JUL 29 1957

RECEIVED

07632

CERTIFICATE OF DEATH

07598

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE			
c. LENGTH OF STAY IN 1b 10 days				d. STREET ADDRESS 4000 VIRGILIA ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE AUGUSTUS FINCH				4. DATE OF DEATH Month Day Year JULY 17 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 22, 1884	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES D. FINCH				14. MOTHER'S MAIDEN NAME EMMA B. FITNAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address ELEANOR H. FINCH 4000 VIRGILIA ST.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 13 days 13 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Bronchial pneumonia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 5, 1957 , to July 17, 1957 , that I last saw the deceased alive on July 16, 1957 , and that death occurred at 1:28 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert N. Coale				M.D. 4630 Montgomery Ave. Bethesda, Md.			
PHYSICIAN'S NAME (Type) Robert N. Coale				DATE SIGNED July 17, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 7-19-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

07560

CERTIFICATE OF DEATH

Reg. Dist. No.

723

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 123 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
f. STREET ADDRESS 8629 Piney Branch Rd.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Erva Estelle Fishback				4. DATE OF DEATH July 12 1957			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/85	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR: Months 7 Days 12 Hours 12 Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Williams B. Jenkins			
14. MOTHER'S MAIDEN NAME Catherine M. Creel				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Chart - Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Postop - hip fracture - general debility - Operation 5-12-57							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 11, 1957 to July 12, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Coleman MD M.D.				ADDRESS (Street, city or town, state) 113 Carroll St. NW. DATE SIGNED 7/12/57			
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN				Washington 12 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hinkle Co. ADDRESS 2901-14th St. N.W.				24. REC'D BY REGISTRAR J. Nelson Duddy DATE JUL 16 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

07633

CERTIFICATE OF DEATH

07600

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 50 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				5. SEX Female			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH December 18, 1925				9. AGE (In years last birthday) 31			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wilbur Wilkins				14. MOTHER'S MAIDEN NAME Edna Langill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO (b) Operative Repair of Mitral Insufficiency DUE TO (c) Rheumatic Heart Dis.; Mitral Insufficiency INTERVAL BETWEEN ONSET AND DEATH 7 days 18 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Insufficiency							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 5, 1957 , to July 25, 1957 , that I last saw the deceased alive on July 25, 1957 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED July 25, 1957							
ACTUAL SIGNATURE John A. Waldhausen M.D. National Institutes of Health							
PHYSICIAN'S NAME (Type) John A. Waldhausen, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 7-27-57							
22c. NAME OF CEMETERY OR CREMATORY Washington DC							
22d. LOCATION (City, town, or county) (State) Portsmouth Va							
23. FUNERAL DIRECTOR'S SIGNATURE Sam Lee Jones ADDRESS Washington DC							
24a. REC'D BY REGISTRAR JUL 29 1957							
24b. REGISTRAR'S SIGNATURE Bessie Thompson							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

Reg. No. 10

<p>NAME OF DECEASED</p> <p>John Doe</p>		<p>DATE OF BIRTH</p> <p>1920</p>		<p>PLACE OF BIRTH</p> <p>1000 Main St., Baltimore, Md.</p>	
<p>DATE OF DEATH</p> <p>July 25, 1957</p>		<p>PLACE OF DEATH</p> <p>1000 Main St., Baltimore, Md.</p>		<p>CAUSE OF DEATH</p> <p>Heart Disease</p>	
<p>SEX</p> <p>Male</p>		<p>AGE</p> <p>37</p>		<p>EDUCATION</p> <p>High School</p>	
<p>OCCUPATION</p> <p>Teacher</p>		<p>RELIGION</p> <p>Methodist</p>		<p>US BIRTH</p> <p>Yes</p>	
<p>DATE OF MARRIAGE</p> <p>1945</p>		<p>NAME OF SPOUSE</p> <p>Jane Doe</p>		<p>NAME OF PHYSICIAN</p> <p>Dr. J. Smith</p>	
<p>DATE OF INTERMENT</p> <p>July 27, 1957</p>		<p>PLACE OF INTERMENT</p> <p>Greenwood Cemetery</p>		<p>NAME OF FUNERAL HOME</p> <p>ABC Funeral Home</p>	
<p>DATE OF REGISTRATION</p> <p>July 28, 1957</p>		<p>NAME OF REGISTRAR</p> <p>John Doe</p>		<p>NAME OF WITNESS</p> <p>John Doe</p>	

BUREAU V. 2

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07601

C7634

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VERMONT</u> b. COUNTY <u>Chittenden</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLESVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WINOOSKI</u> 82 x - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARILEE NURSING HOME</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY FITZGERALD</u>		4. DATE OF DEATH Month Day Year <u>JULY 6 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 8, 1884</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u>	11. BIRTHPLACE (State or foreign country) <u>WINOOSKI, VERMONT</u>
13. FATHER'S NAME <u>JOHN FITZGERALD</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE COFFEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>MRS. THEO. RHAN, 6920 WILLOW ST. NW DC</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4300</u> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized. Arteriosclerotic heart disease.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 June, 1957 to 6 July, 1957, that I last saw the deceased alive on 6 July, 1957, and that death occurred at 4:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Samuel T. Hamble</u>	M.D. <u>929 Pennsylvania Dr. Silver Spring 6 July 57</u>
PHYSICIAN'S NAME (Type) <u>md.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT BURIAL</u>	22b. DATE THEREOF <u>JULY 8, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PLATTSBURGH. NEW YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Orville Walter, 254 Carroll Dr NW. DC</u>		24a. REC'D BY REGISTRAR <u>JUL 8 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		DATE OF BIRTH 1892		PLACE OF BIRTH Maryland	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Teacher		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF DEATH July 5, 1957		PLACE OF DEATH Home	
FATHER'S NAME John H. Harris		MOTHER'S NAME Mary E. Harris		EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married		SPOUSE'S NAME Elizabeth H. Harris	
PREVIOUS ILLNESS Hypertension		TREATMENT Physician's Care		HISTORY OF DEATH Sudden		POST-MORTEM None		CORONER'S NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN James H. Harris		SIGNATURE OF PHYSICIAN Dr. J. K. Smith		SIGNATURE OF CORONER John D. Doe		SIGNATURE OF REGISTRAR Mary E. Harris		SIGNATURE OF WITNESSES None	

BUREAU V. 3

JUL 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07602

C7635

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14 Film C218 8-6-57 et

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont		c. LENGTH OF STAY IN 1b 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4108 Maryland Ave.			d. STREET ADDRESS 4108 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Orlan First Floro Middle Floro Last			4. DATE OF DEATH Month July Day 29 Year 19 57		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/1900	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sgt.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 579-36-9876		
17. INFORMANT Rose W. Smith			Address Same as Item 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found dead on floor of Bed room DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/29/57	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	
22d. LOCATION (City, town, or county) Arlington Virginia		22e. LOCATION (City, town, or county) Arlington Virginia		22f. LOCATION (City, town, or county) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Maryland		DATE 7-31-57	
24a. REC'D BY REGISTRAR Bessie M. Thompson		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson		24c. REGISTRAR'S SIGNATURE Bessie M. Thompson	

07636

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sarasota 48X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 901 Windsor Drive			
3. NAME OF DECEASED (Type or print) First Dorothy Middle Evelyn Last Forbes				4. DATE OF DEATH Month July Day 17 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1910		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton Dolezal				14. MOTHER'S MAIDEN NAME Julia Krivanek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Aortic valvulotomy (c) Rheumatic heart disease, c aortic stenosis						INTERVAL BETWEEN ONSET AND DEATH 9 hrs 15 yrs	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9 , 19 57 , to July 17 , 19 57 , that I last saw the deceased alive on July 17 , 19 57 , and that death occurred at 8:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 18 July 1957 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE James A. McFarland M.D.				PHYSICIAN'S NAME (Type) James A. McFarland M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/57		22c. NAME OF CEMETERY OR CREMATORY Parkman Cemetery		22d. LOCATION (City, town, or county) (State) Parkman, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 7-19-57		24b. REGISTRAR'S SIGNATURE Quinn M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

NAME OF DECEASED JAMES A. BARNARD		DATE OF DEATH JULY 22, 1957	
AGE 68		SEX MALE	
RACE WHITE		BIRTHPLACE NEW YORK	
MARRIAGE MARRIED		WIFE'S NAME JANE BARNARD	
EDUCATION HIGH SCHOOL		OCCUPATION FARMER	
RELIGION METHODIST		MANNER OF DEATH NATURAL	
PLACE OF DEATH HOME		CITY NEW YORK	
STATE NEW YORK		COUNTY SARATOGA	
DATE OF BURIAL JULY 24, 1957		PLACE OF BURIAL PARKMAN CEMETERY	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES JANE BARNARD	
SIGNATURE OF MINISTER J. B. BARNARD		SIGNATURE OF CLERK J. B. BARNARD	

BUREAU V. 8

JUL 22 1957

RECEIVED

Robert A. Barnard-Barnard, Maryland
 7/20/57
 Parkman Cemetery
 James A. Barnard, N.Y.

CERTIFICATE OF DEATH

Reg. Dist. No.

216

07637

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 72 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
f. STREET ADDRESS 1621 Neeley Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Leroy Last Franks				4. DATE OF DEATH Month July Day 3 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 7, 1920	
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 19 Hours 57		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman				10b. KIND OF BUSINESS OR INDUSTRY U. S. Park Police			
13. FATHER'S NAME Alpheus Franks				14. MOTHER'S MAIDEN NAME Gertrude Bean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) Yes (If yes, give year or dates of service) WW II				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA DUE TO (c) BRONCHOGENIC CARCINOMA						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 6 MONTHS 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 22, 1957 , to July 3, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 7/3/57			
ACTUAL SIGNATURE I. Bernard Weinstein, M.D.				National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) I. Bernard Weinstein, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) 3201 Bladensburg Rd. N. E.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 7-10-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Sex Male		Age [Illegible]	
Date of Birth [Illegible]		Place of Birth [Illegible]		Usual Residence [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]		Date of Death December 7, 1950	
Physician's Signature [Illegible]		Medical Examiner's Signature [Illegible]		Signature of Informant [Illegible]	
Address of Informant [Illegible]		Relationship to Deceased [Illegible]		Signature of Informant [Illegible]	

Name of Informant [Illegible]		Address of Informant [Illegible]	
Signature of Informant [Illegible]		Date of Report [Illegible]	
Signature of Medical Examiner [Illegible]		Date of Report [Illegible]	

BUREAU V. 3

JUL 12 1957

RECEIVED

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>15. SIGNATURE OF CLERK [Faint text]</p>		<p>16. SIGNATURE OF JURY [Faint text]</p>	

BUREAU V. 3

JUL 16 1957

RECEIVED

07561

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>56</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Grover</u> Middle <u>Frenier</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-88</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Vermont</u>	
13. FATHER'S NAME <u>Henry Frenier</u>				14. MOTHER'S MAIDEN NAME <u>Reddington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>wife -</u> Address <u>9906 Dilston Rd Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen Arteriosclerosis (Hypertension)</u> DUE TO (c) <u>Uremia -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7/26/57</u> <u>?</u> <u>7/27/57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/26/57</u> , 19 <u>57</u> , to <u>7/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>57</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. T. Morse</u>				ADDRESS (Street, city or town, state) <u>7030 Carroll Ave Takoma Park, Md</u>			
DATE SIGNED <u>8/3/57</u>							
PHYSICIAN'S NAME (Type) <u>H.T. MORSE</u>							
22a. BURIAL, CREMATION, REBURY (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat'l. Mem. Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>				ADDRESS <u>Silver Spring, Maryland</u>		24a. REC'D BY REGISTRAR <u>8/3/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. William Bell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH—BANGOR 18

Form 100-1-55

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. MARITAL STATUS [Faint text]		7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. PLACE OF DEATH [Faint text]		11. DATE OF DEATH [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]		13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF FUNERAL HOME [Faint text]		15. SIGNATURE OF WITNESSES [Faint text]		16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF NEXT OF KIN [Faint text]		18. SIGNATURE OF OTHER [Faint text]		19. SIGNATURE OF OTHER [Faint text]		20. SIGNATURE OF OTHER [Faint text]		21. SIGNATURE OF OTHER [Faint text]		22. SIGNATURE OF OTHER [Faint text]		23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]		25. SIGNATURE OF OTHER [Faint text]		26. SIGNATURE OF OTHER [Faint text]		27. SIGNATURE OF OTHER [Faint text]		28. SIGNATURE OF OTHER [Faint text]		29. SIGNATURE OF OTHER [Faint text]		30. SIGNATURE OF OTHER [Faint text]		31. SIGNATURE OF OTHER [Faint text]		32. SIGNATURE OF OTHER [Faint text]		33. SIGNATURE OF OTHER [Faint text]		34. SIGNATURE OF OTHER [Faint text]		35. SIGNATURE OF OTHER [Faint text]		36. SIGNATURE OF OTHER [Faint text]		37. SIGNATURE OF OTHER [Faint text]		38. SIGNATURE OF OTHER [Faint text]		39. SIGNATURE OF OTHER [Faint text]		40. SIGNATURE OF OTHER [Faint text]		41. SIGNATURE OF OTHER [Faint text]		42. SIGNATURE OF OTHER [Faint text]		43. SIGNATURE OF OTHER [Faint text]		44. SIGNATURE OF OTHER [Faint text]		45. SIGNATURE OF OTHER [Faint text]		46. SIGNATURE OF OTHER [Faint text]		47. SIGNATURE OF OTHER [Faint text]		48. SIGNATURE OF OTHER [Faint text]		49. SIGNATURE OF OTHER [Faint text]		50. SIGNATURE OF OTHER [Faint text]		51. SIGNATURE OF OTHER [Faint text]		52. SIGNATURE OF OTHER [Faint text]		53. SIGNATURE OF OTHER [Faint text]		54. SIGNATURE OF OTHER [Faint text]		55. SIGNATURE OF OTHER [Faint text]		56. SIGNATURE OF OTHER [Faint text]		57. SIGNATURE OF OTHER [Faint text]		58. SIGNATURE OF OTHER [Faint text]		59. SIGNATURE OF OTHER [Faint text]		60. SIGNATURE OF OTHER [Faint text]		61. SIGNATURE OF OTHER [Faint text]		62. SIGNATURE OF OTHER [Faint text]		63. SIGNATURE OF OTHER [Faint text]		64. SIGNATURE OF OTHER [Faint text]		65. SIGNATURE OF OTHER [Faint text]		66. SIGNATURE OF OTHER [Faint text]		67. SIGNATURE OF OTHER [Faint text]		68. SIGNATURE OF OTHER [Faint text]		69. SIGNATURE OF OTHER [Faint text]		70. SIGNATURE OF OTHER [Faint text]		71. SIGNATURE OF OTHER [Faint text]		72. SIGNATURE OF OTHER [Faint text]		73. SIGNATURE OF OTHER [Faint text]		74. SIGNATURE OF OTHER [Faint text]		75. SIGNATURE OF OTHER [Faint text]		76. SIGNATURE OF OTHER [Faint text]		77. SIGNATURE OF OTHER [Faint text]		78. SIGNATURE OF OTHER [Faint text]		79. SIGNATURE OF OTHER [Faint text]		80. SIGNATURE OF OTHER [Faint text]		81. SIGNATURE OF OTHER [Faint text]		82. SIGNATURE OF OTHER [Faint text]		83. SIGNATURE OF OTHER [Faint text]		84. SIGNATURE OF OTHER [Faint text]		85. SIGNATURE OF OTHER [Faint text]		86. SIGNATURE OF OTHER [Faint text]		87. SIGNATURE OF OTHER [Faint text]		88. SIGNATURE OF OTHER [Faint text]		89. SIGNATURE OF OTHER [Faint text]		90. SIGNATURE OF OTHER [Faint text]		91. SIGNATURE OF OTHER [Faint text]		92. SIGNATURE OF OTHER [Faint text]		93. SIGNATURE OF OTHER [Faint text]		94. SIGNATURE OF OTHER [Faint text]		95. SIGNATURE OF OTHER [Faint text]		96. SIGNATURE OF OTHER [Faint text]		97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]		99. SIGNATURE OF OTHER [Faint text]		100. SIGNATURE OF OTHER [Faint text]	
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BUREAU V. S.

AUG 5 1957

RECEIVED

C7639

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 5932 Anniston Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) AGNES A. GARDNER				4. DATE OF DEATH Month July Day 17 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1866	9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) England		
12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.A.							
13. FATHER'S NAME Samuel Lackyer Baker				14. MOTHER'S MAIDEN NAME Elizabeth Jarvis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Daughter Evelyn Gardner			
17. INFORMANT Grinnell College				18. ADDRESS Grinnell, Iowa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HIP FRACTURE R. 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4500 (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 WKS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS - GENERAL + CEREBRAL							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) FELL AT HOME				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 5 p. m. 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME				20f. (City or town) (County) (State) BETHESDA, MONTGOMERY, MD.			
21. I certify that I attended the deceased from July 17, 1957 , to July 17, 1957 , that I lost the deceased alive on July 17, 1957 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE SEYMOUR GREENBAUM, M.D.				ADDRESS (Street, city or town, state) 9300 EWING DR. BETHESDA, MD.			
PHYSICIAN'S NAME (Type) SEYMOUR GREENBAUM, M.D.							
22a. BURIAL, CREMATION, or other disposal Burial Trans		22b. DATE THEREOF 7/19/57		22c. NAME OF CEMETERY OR CREMATORY Flushing Cemetery		22d. LOCATION (City, town, or county) (State) Flushing, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 7-19-57		24b. REGISTRAR'S SIGNATURE Beau M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

6788 (continued)

04 2851 08 201

1903

Samuel L. Taylor, Jr. 1992.02.03

Evelyn Gardner
 Arnold Gardner
 Arnold Gardner
 Arnold Gardner

BUREAU V. S.

1957 22 Jan

RECEIVED

CONFIDENTIAL - SECURITY INFORMATION

Robert J. Murphy - Bethesda, Md.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08653 216
Reg. Dist. No.

07640

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3308 Cummings Lane			d. STREET ADDRESS 3308 Cummings Lane		
3. NAME OF DECEASED (Type or print) Nellie R. GARVER			4. DATE OF DEATH Month July Day 21 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 10 Days 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
13. FATHER'S NAME Thomas Benton Grimm			14. MOTHER'S MAIDEN NAME Adelaide V. Spangler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Helen R. Gleason-Same Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b) - (a), stating the underlying cause lost. (c) - DUE TO - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -					INTERVAL BETWEEN ONSET AND DEATH 50 min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/21/57	
EXAMINER'S NAME (Type) John G. Ball, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/24/1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Hagerstown Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md			24a. REC'D BY REGISTRAR DATE 8/20/57	24b. REGISTRAR'S SIGNATURE Beaue Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Decedent's Name: [illegible]
Sex: [illegible] Age: [illegible]
Date of Birth: [illegible]
Place of Birth: [illegible]
Usual Residence: [illegible]
Cause of Death: [illegible]
Manner of Death: [illegible]
Physician: [illegible]
Hospital: [illegible]
Date of Death: [illegible]
Time of Death: [illegible]
Place of Death: [illegible]
Signature: [illegible]
Title: [illegible]

BUREAU V. 2

AUG 21 1957

RECEIVED

11/24/1957

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07562

Item 2 Film 6219 6-29-57 et

08655

Reg. Dist: No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE - - - MARYLAND b. COUNTY Monte	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	c. LENGTH OF STAY IN 1b 2 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Washington, D. C. 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oakhaven Nursing Home 517 Albany Ave.		d. STREET ADDRESS 517 Albany Ave. 6625 Piney Branch Road N. W.	
3. NAME OF DECEASED (Type or print) Lotta Taylor Gemmill		4. DATE OF DEATH July 28 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/77
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Beau of Engr & Print	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Stevens		14. MOTHER'S MAIDEN NAME Margaret Helen Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clarkson Gemmill, 6625 Piney Branch Road, Takoma Park.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of both breasts with generalized metastasis. 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7/28/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 31, 1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Walter D. Dadd		ADDRESS 254 Carroll St. N. W.	
24a. REC'D BY REGISTRAR 7/31/57		24b. REGISTRAR'S SIGNATURE J. Wilson Dadd	

RECEIVED

AUG 1 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07589

CERTIFICATE OF DEATH

Reg. Dist. No.

07608

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D C b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverley Sanitarium				d. STREET ADDRESS 4000 Cathedral Avenue NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henrietta Middle H. Last Glaser				4. DATE OF DEATH Month July Day 13 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 7, 1866	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D C	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Joseph Herzog				14. MOTHER'S MAIDEN NAME Rachel Hammarschlag			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Irvin Schloss Address 4000 Cathedral Ave NW Washington, D C			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 350x Parkinson's Disease 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from March , 19 56 , to July 13 , 19 57 , that I last saw the deceased alive on July 12 , 19 57 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Garrett Park, Maryland DATE SIGNED ACTUAL SIGNATURE Joseph H. Watson M.D. Garrett Park, Maryland PHYSICIAN'S NAME (Type) JOSEPH H. WATSON, MD GARRETT PARK, MARYLAND 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/15/57 22c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Cong 22d. LOCATION (City, town, or county) (State) Washington D C 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Brown Address 1756 Pennsylvania Ave NW, Washington, DC 24a. REC'D BY REGISTRAR DATE 7/17/57 24b. REGISTRAR'S SIGNATURE Murrell Kratoch							

07563

CERTIFICATE OF DEATH

Reg. Dist. No.

07609

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>2nd.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3rd. Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virginia Katherine Gomez</u>				4. DATE OF DEATH Month Day Year <u>July 25 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1-27-09</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Lewis H. Riggles</u>			14. MOTHER'S MAIDEN NAME <u>Ella Hauke</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>Essential Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 to several yrs</u> <u>1 to 11 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X Cerebral hemorrhage</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 22, 1957</u> , to <u>July 25, 1957</u> , that I last saw the deceased alive on <u>July 25, 1957</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carver Ave Takoma Park</u>			
DATE SIGNED <u>July 25/57</u>							
PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>7/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>				ADDRESS <u>2901-14th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>7/30/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Wilson Duddy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	

C7641

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 hr. 12 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last GREEN				4. DATE OF DEATH Month July Day 7 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 July 1957		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Bobby GREEN				14. MOTHER'S MAIDEN NAME Mary Francis BELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Bobby GREEN (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 12 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Esophageal Atresia & Double Fistula							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6, 1957 , to July 7, 1957 , that I last saw the deceased alive on July 7, 1957 , and that death occurred at 1:22 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 7-9-57							
ACTUAL SIGNATURE J. C. Parke				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) J.C. PARKE, JR. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Eufaula, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR DATE 7-9-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051161XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07642

CERTIFICATE OF DEATH

07612/14

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 210 Southampton Drive				d. STREET ADDRESS 210 Southampton Drive			
3. NAME OF DECEASED (Type or print) First Edith Middle Clokey Last Green				4. DATE OF DEATH Month July Day 29 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/1/1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Samuel Clokey				14. MOTHER'S MAIDEN NAME Ella Hunter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT Betty G. Green- 3304 Collier Road Adelphi, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Cerebral Accident 9 years ago						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 445X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 19 45 , to July 24 , 19 57 , that I last saw the deceased alive on July 24 , 19 57 , and that death occurred at 4:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2021 Que St. N.W. DATE SIGNED ACTUAL SIGNATURE Hugo Einstein M.D. 2021 Que Street, N.W. PHYSICIAN'S NAME (Type) Hugo Einstein							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/1/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W. Washington 9, D.C. DATE AUG 1 1957 REG. BY Frances Patter							

RECEIVED

07643

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>1 yr. 5 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft Sanitarium & Hospital</u>		d. STREET ADDRESS <u>108 E Street, N.W.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle <u>S.</u> Last <u>GREEN</u>	4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>December 30, '65 91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>91</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>David Green</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Edward McGovern, 108 E st., N.W., Wash. D.C.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Bladder</u> <u>181X</u> (b) <u>Senile; brain disease with psychosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Cardio-Vascular Disease</u> DUE TO (c) <u>Senile brain disease with psychosis</u>			INTERVAL BETWEEN ONSET AND DEATH Duration of (a) or (b): <u>Indefinite.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-1-56</u> , 19 <u>56</u> , to <u>7-30-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>57</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alvin J. Kistler</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Cedarcroft Sanitarium, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Alvin J. Kistler, M.D.</u>		<u>Cedarcroft Sanitarium, Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harner & Pumphrey</u>		24a. REC'D BY REGISTRAR <u>7/31/57</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>

8434 GA. AVE. S.S. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07614
273

CERTIFICATE OF DEATH

Reg. Dist. No.

07561

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Rest Home		d. STREET ADDRESS 3909 Benton St. N. W.	
3. NAME OF DECEASED (Type or print) First Mattie Middle P. Last Gregory		4. DATE OF DEATH Month July Day 17 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1872
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Walkersville Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Perry		14. MOTHER'S MAIDEN NAME Martha Gesey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Grace Smith (neice)		Address 3909 Benton St. N.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Paralysis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis Multiple DUE TO (c) Second Anterior - Stroke		INTERVAL BETWEEN ONSET AND DEATH 3 days 14 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2 , 1957, to July 17 , 1957, that I last saw the deceased alive on July 16 , 1957, and that death occurred at 1:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3066 Lehigh Ave. N.W.	
ACTUAL SIGNATURE E. Stuart Lyddane		DATE SIGNED July 22, 1957	
PHYSICIAN'S NAME (Type) E. Stuart Lyddane, M.D.			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 19, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	22d. LOCATION (City, town, or county) (State) Frederick, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		24a. REC'D BY REGISTRAR 22 1957	
ADDRESS 4812 Ga. Ave. N.W. Wash. D. C.		24b. REGISTRAR'S SIGNATURE J. Wilson	

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07615

07644

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> RFD #3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Clyde</u> First Middle Lost <u>Griffith</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-17-1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>JULIAN GRIFFITH</u>	
14. MOTHER'S MAIDEN NAME <u>MARY VIRGINIA HARPER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>217-36-8423</u>		17. INFORMANT <u>Miss Alice Griffith (Daughter)</u> Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary artery thrombosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular renal disease</u> years		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis 725X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb-5-1957</u> , to <u>July-18-1957</u> , that I last saw the deceased alive on <u>July-17-1957</u> , and that death occurred at <u>7:14</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.		DATE SIGNED <u>7-Brooks Ave., Gaithersburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		<u>GAITHERSBURG, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Darnestown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Galtner</u> ADDRESS <u>Gaithersburg</u>		24a. REC'D BY REGISTRAR <u>7-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

FILE NO.

MARRIED

Montgomery

Washington

Washington

Griffith

Male white

BUREAU V. 3

JUL 26 1957

RECEIVED

07590

CERTIFICATE OF DEATH

Reg. Dist. No.

2 13

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>2 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Abigail Elizabeth Grignon</u>				4. DATE OF DEATH Month Day Year <u>July 13 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/16/80</u>		9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>N. Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Griffin</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET HARTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>son - Henry Grignon - Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardiovascular Disease</u> 15 yr. DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> 19 <u>55</u> , to <u>July 12</u> 19 <u>57</u> , that I last saw the deceased alive on <u>July 12</u> 19 <u>57</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>7/13/57</u> ACTUAL SIGNATURE <u>Stephen C. Cromwell</u> M.D. PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell, M.D.</u> <u>Rockville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 13 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellows Falls VT.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.W. Tatteruell 3619-14th A NW</u>				24a. REC'D BY REGISTRAR DATE <u>15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Lawrence Kratoch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. RACE [Faint text]		4. AGE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]		7. PLACE OF DEATH [Faint text]	
8. OCCUPATION [Faint text]		9. MARITAL STATUS [Faint text]		10. EDUCATION [Faint text]		11. RELIGION [Faint text]		12. SOCIAL SECURITY NUMBER [Faint text]		13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]	
15. CAUSE OF DEATH [Faint text]		16. MANNER OF DEATH [Faint text]		17. PLACE OF DEATH [Faint text]		18. NAME OF PHYSICIAN [Faint text]		19. NAME OF HOSPITAL [Faint text]		20. NAME OF NURSE [Faint text]		21. NAME OF ATTENDING PHYSICIAN [Faint text]	
22. SIGNATURE OF PHYSICIAN [Faint text]		23. SIGNATURE OF HOSPITAL [Faint text]		24. SIGNATURE OF NURSE [Faint text]		25. SIGNATURE OF ATTENDING PHYSICIAN [Faint text]		26. SIGNATURE OF DECEASED [Faint text]		27. SIGNATURE OF WITNESSES [Faint text]		28. SIGNATURE OF REGISTRAR [Faint text]	

BUREAU V. 3

JUL 15 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07617

07645

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>R.R. #12</u>			
3. NAME OF DECEASED (Type or print) First <u>Billie</u> Middle <u>WAYNE</u> Last <u>GRIMES</u>				4. DATE OF DEATH July 9 1957			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 10, 1957</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>29</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Montgomery County</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ernest Wilson GRIMES SR.</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Catherine Slick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Ernest Wilson GRIMES SR. (Father)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA - BILATERAL</u> 493x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>57</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/9</u> 19 <u>57</u> to <u>7/9</u> 19 <u>57</u> , that I last saw the deceased alive on <u>7/9</u> 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Peulman</u>				ADDRESS (Street, city or town, state) <u>4922 - BRADLEY BLVD. CH. MD.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Type)		22b. DATE THEREOF <u>July 12, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon</u>		22d. LOCATION (City, town, or county) (State) <u>Ethelton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u>				ADDRESS <u>Laytonville, Md.</u>		24a. REC'D BY REGISTRAR <u>7-13-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bennie M. [unclear]</u>							

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JUL 6, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		JUL 6, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
JUL 16 1968
BUREAU V. 2

C7646

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Petersburg 48x-3			
d. STREET ADDRESS 3644 Burlington Ave., North				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle Girard Last GROSSHANS				4. DATE OF DEATH Month July Day 11 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Feb. 1933	
9. AGE (In years lost birthday) 24 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Paul Grosshans				14. MOTHER'S MAIDEN NAME Ethyl BRASHEARS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Currently				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Dorothy L. GROSSHANS (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Leukemia, myelogenous acute DUE TO (c) 3 weeks INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9 July , 19 57 , to 11 July , 19 57 , that I last saw the deceased alive on 11 July , 19 57 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Gerald I. Shugoll U.S. Naval Hospital, Bethesda, Md. 7-12-57							
ACTUAL SIGNATURE Gerald I. Shugoll				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Gerald I. Shugoll, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-16-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR May E. Parnelly		24b. REGISTRAR'S SIGNATURE May E. Parnelly	
R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				DATE 7-12-57			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED J. J. ROBERTSON		SEX Male		AGE 68	
DATE OF DEATH July 15, 1957		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF BIRTH Maryland	
DATE OF BIRTH July 15, 1889		PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore	
OCCUPATION None		EDUCATION None		RELIGION None	
MARRIAGE None		CHILDREN None		SIGNED BY None	
WITNESSES None		DOCTOR None		CITY Baltimore	
STATE Maryland		COUNTY None		CITY Baltimore	

BUREAU V. S.

RECEIVED

JUL 15 1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Item 8:G219 8-29-57 Item 1 Film G218 8-5-57 et

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY 07647 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5212 Baltimore Avenue		d. STREET ADDRESS 5212 Baltimore Avenue	
3. NAME OF DECEASED (Type or print) IRENE MacDONALD		4. DATE OF DEATH Month July Day 20 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898 4-8-1898
9. AGE (in years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 3 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY US Government	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Donald MacDonald		14. MOTHER'S MAIDEN NAME Unk Penn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Vincent M. Hancock, 52 12 Baltimore, AVE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Gangrenous Appendicitis (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John L. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN G. BALL, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 21 July 57.	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 7-23, 1957	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Seulers		ADDRESS 1756 Pa. Ave. NW D.C.	
24a. REC'D BY REGISTRAR DATE 7-27-57		24b. REGISTRAR'S SIGNATURE Bessie M. Horn	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
JAMES J. HANCOCK		Male		65		JUL 10 1892		NEW YORK		NEW YORK		HEART DISEASE		NATURAL	
Occupation		Education		Marital Status		Date of Marriage		Date of Death		Time of Death		Place of Death		Physician's Name	
Clerk		High School		Married		JUL 10 1915		JUL 28 1957		10:00 AM		NEW YORK		DR. J. J. HANCOCK	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Deceased		Signature of Next of Kin		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

JUL 30 1957

RECEIVED

JOHN C. BAIL, MD.
JUL 28 1957
JUL 28 1957
JUL 28 1957

07565

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>7222 Flower Ave</i> b. COUNTY <i>Montg.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 TAKOMA PARK, Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WASHINGTON SANITARIUM & HOSPITAL</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Timothy</i> Middle <i>Joseph</i> Last <i>HANLEY</i>				4. DATE OF DEATH Month <i>July</i> Day <i>18</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/3/77</i>	
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK - R.R.</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MASS.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>JOHN HANLEY</i>				14. MOTHER'S MAIDEN NAME <i>MARGARET KELLEY</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <i>014-07-4309</i>		17. INFORMANT <i>daughter Ellen HANLEY</i> Address <i>7222 Flower Ave TAKOMA PARK, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Nephritis</i> <i>592X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>① Infected Bromodermia, skin ② Secondary Anemia</i>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>april</i> , 1956, to <i>July 18</i> , 1957, that I last saw the deceased alive on <i>July 18</i> , 1957, and that death occurred at <i>5:55 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>113 Carroll St NW, Wash DC</i> DATE SIGNED <i>7/18/57</i>							
ACTUAL SIGNATURE <i>Dean H. Harding</i> M.D.							
PHYSICIAN'S NAME (Type) <i>DEAN H. HARDING</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 20, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW, H.C.</i>				24a. REC'D BY REGISTRAR DATE <i>7/20/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. H. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWER	
40. SIGNATURE OF INTERVIEWER		41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWER	
43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

RECEIVED
JUL 22 1957
BUREAU V. S.

CERTIFICATE OF DEATH

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07621

CERTIFICATE OF DEATH

Reg. Dist. No. 216

C7648

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6m days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Andrew Christian Hansen</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1918-Oct. 26</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u>38</u> Days <u>30</u> Hours <u>30</u> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Indus.</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois - Cook</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Clarence Hansen</u>				14. MOTHER'S MAIDEN NAME <u>Wilhemina Hatzel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1942-45</u>		17. INFORMANT <u>Mrs. Geraldine Hansen (Wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> <u>330x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Congenital Aneurysm of Rt. Middle Cerebral Artery</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 12, 1957</u> , to <u>July 17, 1957</u> , that I last saw the deceased alive on <u>July 17, 1957</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>July 17, 1957</u>							
ACTUAL SIGNATURE <u>John T. Lord</u>				M.D. <u>John T. Lord</u>			
PHYSICIAN'S NAME (Type) <u>JOHN T. LORD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 22, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maxwell E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-28-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Humphrey</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1912		BALTIMORE, MD	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1935		BALTIMORE, MD		JANE HARRIS		JULY 25, 1957		BALTIMORE, MD	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		1945		BALTIMORE, MD		BALTIMORE, MD		HEART DISEASE		NATURAL	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		NAME OF SCHOOL		PREVIOUS ILLNESS		TREATMENT	
HIGH SCHOOL		1930		BALTIMORE, MD		BALTIMORE, MD		NONE		NONE	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		NAME OF CHURCH		SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE	
CATHOLIC		1930		BALTIMORE, MD		BALTIMORE, MD		J. H. HARRIS		JULY 25, 1957	
SIGNATURE OF DECEASED		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF SIGNER		SIGNATURE OF WITNESS		DATE OF SIGNATURE	
JAMES H. HARRIS		1957		BALTIMORE, MD		JAMES H. HARRIS		JANE HARRIS		JULY 25, 1957	

BUREAU A. B.

JUL 25 1957

RECEIVED

DATE OF RECEIPT		PLACE OF RECEIPT		NAME OF OFFICIAL		TITLE OF OFFICIAL	
JUL 25, 1957		BALTIMORE, MD		J. H. HARRIS		DEPUTY COMMISSIONER	

07649

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 53 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 18005 N.W. 8th Place			
3. NAME OF DECEASED (Type or print) First Robert Middle Bernard Last HOLDEN				4. DATE OF DEATH Month July Day 13 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Jan. 1921	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Felix F. HOLDEN				14. MOTHER'S MAIDEN NAME Grace Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 2-14-58 to 4-1-52		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Wife) Margarita HOLDEN (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Mitral Valve Stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 years Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 178X Metastatic embryonal (Testicular) carcinoma						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 21 May , 19 57 , to 13 July , 19 57 , that I last saw the deceased alive on 13 July , 19 57 , and that death occurred at 11:23 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. J. Mc Carthy				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 7-15-57			
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR 7-15-57		24b. REGISTRAR'S SIGNATURE Bray E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JUL 16 1957

RECEIVED

7650

CERTIFICATE OF DEATH

Reg. Dist. No. 215 23

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 58 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS Alexandria 83X-3 37 South French Street			
3. NAME OF DECEASED (Type or print) First Charles Middle Franklin Last HUDSON				4. DATE OF DEATH Month July Day 3 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1887		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner			10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Alfred Brown HUDSON				14. MOTHER'S MAIDEN NAME Rose WEBER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI & WWII		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Son) Charles F. HUDSON, Jr. (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis, Severe DUE TO (c) indefinite						INTERVAL BETWEEN ONSET AND DEATH indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 6, 1957 to July 3, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 10:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 7-4-57							
ACTUAL SIGNATURE R. J. Mc Carthy				M.D. U.S. Naval Hospital, Bethesda, Md. 7-4-57			
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7757 Wisc. Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 7-4-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Farrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 15 1957

RECEIVED

07651

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland/Florida</u> b. COUNTY <u>Escambia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> <u>Pensacola</u> 48X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>				d. STREET ADDRESS <u>437 Beverly Parkway</u> <u>U.S. Naval Air Station</u> (See birth cert.)			
3. NAME OF DECEASED (Type or print) First <u>Nick</u> Middle <u>Charles</u> Last <u>ICE, Jr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 July 1957</u>	9. AGE (In years lost birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	IF UNDER 24 HRS. Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nick Charles ICE, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Edna Rose DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address (Father) <u>Nick Charles ICE, Sr. (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>774x</u> DUE TO <u>Pulmonary Hyaline Membrane Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>28 July</u> , 19 <u>57</u> , to <u>29 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 July</u> , 19 <u>57</u> , and that death occurred at <u>5:25 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>7-30-57</u>							
ACTUAL SIGNATURE <u>Russell Miller, Jr.</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Russell Miller, Jr. LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2 August 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brentwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pensacola, Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u>				ADDRESS <u>7557 Wisconsin Ave, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>7-30-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary E. Parnelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 1.5.11

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp -</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Milford</u> Middle <u>D.</u> Last <u>Jarvis</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>M-</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milford Meade Jarvis</u>				14. MOTHER'S MAIDEN NAME <u>Rose Emily Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Milford D. Jarvis</u> Address <u>5802 Riggs Rd. Chillum Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS -</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GEN. ARTERIO SCLEROSIS +</u> DUE TO (c) <u>SENILITY</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 HRS</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1957</u> , to <u>July 1, 1957</u> , that I last saw the deceased alive on <u>July 1, 1957</u> , and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. Ziegler</u>				ADDRESS (Street, city or town, state) <u>Olney Md</u> DATE SIGNED <u>2 July 57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. John B. Ziegler</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Robert Church</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax Co. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. W. Lee + Son's Co.</u>				ADDRESS <u>300 4th N.E. Wash. D.C.</u>		24. REC'D BY REGISTRAR DATE <u>JUL 5 1957</u>	
				25. REGISTRAR'S SIGNATURE <u>Estelle Lawler</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE DATE		MARRIAGE PLACE	
PREVIOUS MARRIAGES		PREVIOUS DEATHS	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL HISTORY		MENTAL HISTORY	
TREATMENT		HOSPITAL	
SURGEON		PATHOLOGIST	
CORONER		BURIAL PLACE	
BURIAL DATE		BURIAL TIME	
BURIAL PLACE		BURIAL TIME	

BUREAU V. 3

JUL 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07653

CERTIFICATE OF DEATH

07626

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14326 Colesville Rd., Mrs. Green's Nursing Home				d. STREET ADDRESS 1434 Geranium St. N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Katherine V. Johnston				4. DATE OF DEATH Month July Day 14 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/8/1867	
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel M. Dalzell				14. MOTHER'S MAIDEN NAME Louise V. Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Alvin Wilson Luckett 1434 Geranium St. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses 332x DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) 20+ years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January , 19 57 , to July 14 , 19 57 , that I last saw the deceased alive on July 6 , 19 57 , and that death occurred at 7:40 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED R. Stephen Hulburt M.D. 3000 Dent Place, N.W. July 14, 1957 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) R. Stephen Hulburt, M.D. Washington 7, D.C.							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF 7/16/1957		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				24a. REC'D BY REGISTRAR DATE 11 16 1957		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		JULY 16 1968	
AGE		SEX	
35		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JAN 19 1933		MOBILE, ALABAMA	
MARRIAGE DATE		MARRIAGE PLACE	
JULY 1967		MEMPHIS, TENNESSEE	
OCCUPATION		CAUSE OF DEATH	
Attorney		Suicide	
PLACE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENNESSEE		Suicide	
HOSPITAL		CERTIFICATE OF DEATH	
MEMPHIS HOSPITAL		JULY 16 1968	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE	
JULY 16 1968		JULY 16 1968	

BUREAU V. S.

JUL 16 1968

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

07654

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE North Carolina COUNTY Duplin Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warsaw 70X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS R.F.D. #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roland Middle Jack Last Johnston				4. DATE OF DEATH Month July Day 23, Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 3, 1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 20 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Will J. Johnston				14. MOTHER'S MAIDEN NAME Annie Melville			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic malignant melanoma 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobular pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22, 19 57 , to July 23, 19 57 , that I last saw the deceased alive on July 23, 19 57 , and that death occurred at 5:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/23/57							
ACTUAL SIGNATURE Edward W. Moore		M.D. The Clinical Center		NATIONAL INSTITUTES OF HEALTH		BETHESDA 14, MARYLAND	
PHYSICIAN'S NAME (Type) Edward W. Moore							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/57		22c. NAME OF CEMETERY OR CREMATORY Pine Crest Cemetery		22d. LOCATION (City, town, or county) (State) Warsaw, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 7-23-57	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

R. D. A.

2

BUREAU A.

JUL 25 1957

RECEIVED

02/25/06

www.elsevier.com/locate/jmb

07655

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>21 Years</u>				d. STREET ADDRESS <u>8401 Dixon Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8401 Dixon Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Jr.</u> Last <u>Joyce</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1 1972</u>	
				9. AGE (In years, last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian - Guardian Bldg. & Loan</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ireland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Joyce</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Kessiry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-05-72-7A</u>		17. INFORMANT <u>Lawrence Joyce</u> Address <u>1745 Oakbrook Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardio-vascular disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332 X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 15</u> , 1953, to <u>July 9</u> , 1957, that I last saw the deceased alive on <u>July 8</u> , 1957, and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Bradshaw</u>				ADDRESS (Street, city or town, state) <u>345 University Boulevard, West 7/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>				DATE SIGNED <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>7/12/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Potter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, and 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, and 6 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

C7656

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midway Island 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS #6 Marvel Manor			
3. NAME OF DECEASED (Type or print) First Mary Middle Kathryn Last KAHLER				4. DATE OF DEATH Month July Day 5 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1916		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Housewife)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James S. Kimsey				14. MOTHER'S MAIDEN NAME Olive Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Husband) Jack W. KAHLER (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombocytopenic Purpura 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skeletal Metastases DUE TO (c) Carcinoma of Breast						INTERVAL BETWEEN ONSET AND DEATH 3 months 15 months 22 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 296X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12 May , 19 57 , to 5 July , 19 57 , that I last saw the deceased alive on 5 July , 19 57 , and that death occurred at 12:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George W. Russell U.S. Naval Hospital, Bethesda, Md. 7-5-57							
ACTUAL SIGNATURE George W. Russell		M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) George W. Russell, CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-12-57	22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Stella, Nebraska			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 158 Wisconsin Ave, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 7-5-57	24b. REGISTRAR'S SIGNATURE Mary E. Parrelly		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		65		1892		BALTIMORE		MD		MD		USA	
MARRIAGE		MARRIED		DATE		PLACE		CITY		STATE		COUNTRY			
MARRIED		MARRIED		1915		BALTIMORE		MD		MD		USA			
EDUCATION		EDUCATION		SCHOOL		CITY		STATE		COUNTRY					
SCHOOL		SCHOOL		1910		BALTIMORE		MD		MD		USA			
OCCUPATION		OCCUPATION		OCCUPATION		CITY		STATE		COUNTRY					
OCCUPATION		OCCUPATION		OCCUPATION		1910		BALTIMORE		MD		MD		USA	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CITY		STATE		COUNTRY					
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		1910		BALTIMORE		MD		MD		USA	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		CITY		STATE		COUNTRY					
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		1910		BALTIMORE		MD		MD		USA	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		CITY		STATE		COUNTRY					
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		1910		BALTIMORE		MD		MD		USA	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY					
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		1910		BALTIMORE		MD		MD		USA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		CITY		STATE		COUNTRY					
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		1910		BALTIMORE		MD		MD		USA	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		CITY		STATE		COUNTRY					
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		1910		BALTIMORE		MD		MD		USA	

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RECEIVED

07566

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Gerard</u> Middle <u>Kaufmann</u> Last <u>Kaufmann</u>			4. DATE OF DEATH Month <u>7</u> - Day <u>7</u> - Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-13</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Siegfried Kaufmann</u>		14. MOTHER'S MAIDEN NAME <u>Frieda Lerig</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Washington Sanitarium Hospital Records</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Card Failure</u> 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOGENIC CARCINOMA WITH METASTASES</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7</u> DAYS <u>ABOUT 9 months</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7824</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCT 10, 1956 to JULY 7, 1957, that I lost saw the deceased alive on JULY 6, 1957, and that death occurred at 530 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Robert L. Krichmar</u>	M.D. <u>7733 MARYLAND AVE. N.W. WASH DC</u>	DATE SIGNED <u>JULY 1957</u>
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR M.D.</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Wanzanovsky</u>	ADDRESS <u>3501-14 St. N.W.</u>	24. REC'D BY REGISTRAR <u>J. W. Noddy</u>	25. REGISTRAR'S SIGNATURE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

REG. NO. 100

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. DATE OF BIRTH</p> <p>4. PLACE OF BIRTH</p> <p>5. OCCUPATION</p> <p>6. MARITAL STATUS</p> <p>7. COLOR</p> <p>8. RELIGION</p> <p>9. EDUCATION</p> <p>10. PREVIOUS ILLNESS</p> <p>11. CAUSE OF DEATH</p> <p>12. PLACE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. SIGNATURE OF PHYSICIAN</p> <p>15. SIGNATURE OF REGISTRAR</p> <p>16. SIGNATURE OF WITNESSES</p> <p>17. SIGNATURE OF DECEASED</p> <p>18. SIGNATURE OF NEXT OF KIN</p> <p>19. SIGNATURE OF BURIAL OFFICIAL</p> <p>20. SIGNATURE OF FUNERAL HOME</p> <p>21. SIGNATURE OF CHURCH</p> <p>22. SIGNATURE OF CEMETERY</p> <p>23. SIGNATURE OF INTERVIEWER</p> <p>24. SIGNATURE OF INTERVIEWEE</p> <p>25. SIGNATURE OF INTERVIEWER'S SUPERVISOR</p> <p>26. SIGNATURE OF INTERVIEWEE'S SUPERVISOR</p> <p>27. SIGNATURE OF INTERVIEWER'S SUPERVISOR'S SUPERVISOR</p> <p>28. SIGNATURE OF INTERVIEWEE'S SUPERVISOR'S SUPERVISOR</p> <p>29. SIGNATURE OF INTERVIEWER'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR</p> <p>30. SIGNATURE OF INTERVIEWEE'S SUPERVISOR'S SUPERVISOR'S SUPERVISOR</p>	
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BUREAU V. S.

JUL 10 1957

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07567

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN TB 2 yrs. 4 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Haven Rest Home Balto. Ave. 7300				d. STREET ADDRESS 1115 Wisconsin Ave., N.W.			
3. NAME OF DECEASED (Type or print) Mary E. Jarvis Keely				4. DATE OF DEATH July 15, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1867	
9. AGE (In years lost birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -- James				14. MOTHER'S MAIDEN NAME --- Franks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT William B. Keely- 5312 N. 32nd Street Arlington, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 General arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 28, 1945 to July 15, 1957 , that I last saw the deceased alive on July 14, 1957 , and that death occurred at 6:12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 915 - 19th Street, N.W. Washington 6, D.C. DATE SIGNED							
ACTUAL SIGNATURE Luther H. Snyder M.D.				PHYSICIAN'S NAME (Type) Luther H. Snyder			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/18/1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Himes Co.-2901 14th St., N.W.				24a. REC'D BY REGISTRAR 177957		24b. REGISTRAR'S SIGNATURE J. Nelson Diddy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

07657

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernest Middle Laurence Last Kendall				4. DATE OF DEATH Month July Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 5, 1955	
9. AGE (In years lost birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Fredric L. Kendall				14. MOTHER'S MAIDEN NAME Barbara Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia DUE TO 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 204.0 DUE TO (c) 204.0 INTERVAL BETWEEN ONSET AND DEATH 7 Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 12 , 19 57 , to July 6 , 19 57 , that I last saw the deceased alive on July 6 , 19 57 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/7/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Kurt Kohn M. D.							
PHYSICIAN'S NAME (Type) KURT KOHN, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey ADDRESS Silver Spring, Md.				24a. REC'D BY REGISTRAR 7-10-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 12 1957

BUREAU V. 1

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08687

Reg. Dist. No. 212

07591

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boolesville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Boolesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Willard Rd</u>				d. STREET ADDRESS <u>Willard Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Steve Kidd</u>				4. DATE OF DEATH Month Day Year <u>July 31 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-94</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>W. Kidd</u>				14. MOTHER'S MAIDEN NAME <u>Ann Sears</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>				16. SOCIAL SECURITY NO. <u>495-49059-230-09-30</u>		17. INFORMANT <u>Virginia Kidd (wife)</u> Address <u>Same # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>241X Bronchial Asthma - 20 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-31-57</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>				24a. REC'D BY REGISTRAR DATE <u>8/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. F.

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07633

07658

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New York</u> b. COUNTY <u>Chautauqua</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b. <u>11 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jamestown</u> 69X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS <u>101 Maple St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Charles Kiley</u> First Middle Last				4. DATE OF DEATH <u>July 22</u> Month Day Year 19 <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1879</u> 78 yrs.	
9. AGE (In years last birthday) <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>←</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Kiley</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Gaskin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-12-3285</u>		17. INFORMANT <u>Eva Kiley Baker</u> Address <u>5611 Trentree Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>August 11, 1956</u> to <u>July 8, 1957</u> , that I last saw the deceased alive on <u>July 8, 1957</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Allen J. O'Neill</u> M.D. <u>July 22, 1957</u> ADDRESS (Street, city or town, state) <u>8601 Old Georgetown Rd, Bethesda</u> DATE SIGNED <u>Md.</u>							
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.-Transit</u>		22b. DATE THEREOF <u>7/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lakeview</u>		22d. LOCATION (City, town, or county) (State) <u>Jamestown. New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>7-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 2

JUL 25 1957

RECEIVED

Form with fields for registration and filing, including date and location. The text is mostly illegible due to blurring and bleed-through.

07659

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
f. STREET ADDRESS 1615 Bradley Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ned Middle Edward Last King				4. DATE OF DEATH Month July Day 22 , Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1916		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Painter		10b. KIND OF BUSINESS OR INDUSTRY Advertising		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John King				14. MOTHER'S MAIDEN NAME Jennie Seebold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) increased intracranial pressure 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) glioblastoma multiforme DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 days 10+ days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22, 1957 , to July 22, 1957 , that I last saw the deceased alive on July 22, 1957 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 7/23/57 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Norman H. Bell		M.D.					
PHYSICIAN'S NAME (Type) N. H. Bell, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 7-24-57	
				24b. REGISTRAR'S SIGNATURE Desain M. Hornspon			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997

1995

BUREAU V. 8

JUL 26 1957

RECEIVED

07660

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X14232 HOWARD AVE.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>1 KENSINGTON</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN FRANKLIN KROUSE</u>				4. DATE OF DEATH Month Day Year <u>JULY 24 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 2-1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>GEORGE S. KROUSE</u>			
14. MOTHER'S MAIDEN NAME <u>ELLA HOLLINGSWORTH.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>CASSIUS KROUSE - BROTHER.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 22, 1957</u> , to <u>July 24, 1957</u> , that I last saw the deceased alive on <u>July 23, 1957</u> , and that death occurred at <u>6:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen C. Cromwell</u> M.D. <u>615 W. Montgomery Ave. Rockville, Md.</u>				DATE SIGNED <u>7/24/57</u>			
PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-27-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		APR 4 1968		MEMPHIS, TENN.	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF RESIDENCE		COUNTRY OF RESIDENCE		OCCUPATION		CAUSE OF DEATH	
MAY 19 1932		MEMPHIS, TENN.		MEMPHIS, TENN.		U.S.A.		ATTORNEY AT LAW		HEART DISEASE	
MANNER OF DEATH		EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF DEATH	
NATURAL		HIGH SCHOOL		METHODIST		MARRIED		MAY 1967		APR 4 1968	
DATE OF DEATH		PLACE OF DEATH		CITY OF RESIDENCE		COUNTRY OF RESIDENCE		OCCUPATION		CAUSE OF DEATH	
APR 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		U.S.A.		ATTORNEY AT LAW		HEART DISEASE	
MANNER OF DEATH		EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF DEATH	
NATURAL		HIGH SCHOOL		METHODIST		MARRIED		MAY 1967		APR 4 1968	

BUREAU V. S.

MIL 30 1957

RECEIVED

07661

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Disctric of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5036 Wisconsin Avenue, N. W. 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Washington, D. C.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theodore H Kurtz</u>		4. DATE OF DEATH Month Day Year <u>July 10 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Kurtz</u>		14. MOTHER'S MAIDEN NAME <u>Louise ??</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>368-30-9389</u>	
17. INFORMANT <u>Medical Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal Obstruction</u> DUE TO (c) <u>Carcinom a of Recto-Sigmoid Colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>48 Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 9</u> , 19 <u>57</u> , to <u>July 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>57</u> , and that death occurred at <u>1:07 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington, D. C.</u> DATE SIGNED <u>7-10-57</u>			
ACTUAL SIGNATURE <u>P. P. Andrews</u>		M.D. <u>Washington, D. C.</u>	
PHYSICIAN'S NAME (Type) <u>P. P. Andrews</u>		M.D. <u>4201 Fessenden St. N. W. Wash. D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	22b. DATE THEREOF <u>7/11/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>?</u>	22d. LOCATION (City, town, or county) (State) <u>Detroit Michigan</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 7-13-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07662

CERTIFICATE OF DEATH

07637

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Sipsey			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sipsey			
c. LENGTH OF STAY IN 1b 49 days				d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Horace Middle John Last Land				4. DATE OF DEATH Month July Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1939	
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 15 Min.		IF UNDER 24 HRS. Months 10 Days 10 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Talmadge Land				14. MOTHER'S MAIDEN NAME Edna Bland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record address Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas Septicemia INTERVAL BETWEEN ONSET AND DEATH 3 wks 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Infected Suture Line 5 wks DUE TO (c) Transaortic Valvulotomy 5 wks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 22 19 57 , to July 10 19 57 , that I last saw the deceased alive on July 10 19 57 , and that death occurred at 1:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/10/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE John A. Waldhausen M.D.		PHYSICIAN'S NAME (Type) John A. Waldhausen					
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 7/11/57		22c. NAME OF CEMETERY OR CREMATORY --		22d. LOCATION (City, town, or county) (State) Sipsey, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., -2901 14th St., N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR JUL 12 '57	
				24b. REGISTRAR'S SIGNATURE Beauregard Thompson			

BUREAU V.

RECEIVED

07568

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
c. LENGTH OF STAY IN 1b 13 days				d. STREET ADDRESS 7309 Willow Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Freedom Rosecoe Heaman				4. DATE OF DEATH July 7 1957			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) G.S. P.O. Clerk				10b. KIND OF BUSINESS OR INDUSTRY Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isaac Heaman				14. MOTHER'S MAIDEN NAME Minerva Mc Kown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO YES. NATL GUARD				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mabel L. Heaman, (same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Circulatory failure - (shock) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cerebral thrombosis. DUE TO (c) 2 wks				INTERVAL BETWEEN ONSET AND DEATH 2 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2040 Chronic lymphatic leukemia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 1956 , to July 7, 1957 , that I last saw the deceased alive on July 7, 1957 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Coleman, M.D.				ADDRESS (Street, city or town, state) 113 Carroll St NW Washington 12 DC		DATE SIGNED 7/7/57	
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Hatten				ADDRESS 254 Carroll St NW		24. REC'D BY REGISTRAR J. M. H. Hatten	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

07663

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 10231 Carroll Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mabelle Middle Odeal Last Lewis				4. DATE OF DEATH Month July Day 29 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 5, 1882		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lyman Truman				14. MOTHER'S MAIDEN NAME Mary Beers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? PULMONARY EMBOLUS 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ?? THROMBOPHLEBITIS, OCCULT. DUE TO (c) CARCINOMA OF RT. BREAST.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 464x							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 10, 1957 to July 29, 1957 , that I last saw the deceased alive on July 29, 1957 , and that death occurred at 5:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/29/57 ACTUAL SIGNATURE Allen D. Goodman, M.D. M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Allen D. Goodman, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cremation		7/31/57		Cedar Hill Cem		Frederick Md	
23. FUNERAL DIRECTOR'S SIGNATURE Chung Chang Funeral Home				ADDRESS 5103 King Ave		24. REC'D BY REGISTRAR DATE 7-31-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore, Md.		DECEASED Robert H. Johnson	
DATE OF DEATH July 10, 1957		AGE 45 years	
SEX Male		RACE White	
OCCUPATION Government		MARITAL STATUS Married	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH July 2, 1912	
NAME OF PHYSICIAN Dr. Robert H. Johnson		NAME OF HOSPITAL The Clinical Center, Baltimore, Md.	
NAME OF FUNERAL HOME Johnson & Sons		NAME OF BURIAL PLACE Green-Wood Cemetery, Baltimore, Md.	
NAME OF NEXT OF KIN Mrs. Robert H. Johnson		NAME OF WITNESS Dr. Robert H. Johnson	
NAME OF REGISTRAR Robert H. Johnson		NAME OF CLERK Robert H. Johnson	

BUREAU V. 2

AUG 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07664

CERTIFICATE OF DEATH

07641

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTG. Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MD b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1902 Maple Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle ANIX Last Lewis				4. DATE OF DEATH Month July Day 17 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-77	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 5 Days 4 Hours 1 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY TENN	
11. BIRTHPLACE (State or foreign country) TENN				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME DAVID MORGAN				14. MOTHER'S MAIDEN NAME LUZANNA Dodson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of pancreas DUE TO (c) with hepatic metastases							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 , to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. P. McCarrick				ADDRESS (Street, city or town, state) Rockville Md.		DATE SIGNED 7-17-57	
PHYSICIAN'S NAME (Type) J. P. McCarrick							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/57		22c. NAME OF CEMETERY OR CREMATORY Woods Cemetery		22d. LOCATION (City, town, or county) (State) Tazwell, Tennessee	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Maryland		24a. REC'D BY REGISTRAR DATE 7-19-57	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>David J. Jones</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>July 22, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Jones</i>	
16. SIGNATURE OF REGISTRAR <i>John D. Smith</i>		17. DATE OF REGISTRATION <i>July 23, 1957</i>		18. OFFICIAL SEAL <i>Seal of the State Department of Health</i>	

BUREAU V. 3

JUL 22 1957

RECEIVED

07665

CERTIFICATE OF DEATH

Reg. Dist. No. 215

07642

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN TB 33 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1607 Bradley Ave.			
3. NAME OF DECEASED (Type or print) First Herve Middle Joseph Last L'HEUREUX				4. DATE OF DEATH Month July Day 9 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 March 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) New Hampshire	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Rodolphe L'HEUREUX				14. MOTHER'S MAIDEN NAME Pichette Desneiges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, sigmoid colon with 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) generalized metastases DUE TO (c) 2 years.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 June , 19 57 , to 9 July , 19 57 , that I last saw the deceased alive on 9 July , 19 57 , and that death occurred at 3:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-10-57							
ACTUAL SIGNATURE D. P. Osborne				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) D. P. OSBORNE, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 July 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's & Sons, 1756 Penn. Ave., N.W. Wash. D.C.				24a. REC'D BY REGISTRAR DATE 7-10-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "Jan 1, 1910"]	
PLACE OF BIRTH [Faint text, possibly "West Virginia"]		OCCUPATION [Faint text, possibly "Farmer"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "July 12, 1957"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF DEATH REGISTRAR [Faint signature]	
COUNTY [Faint text, possibly "Mingo"]		STATE [Faint text, possibly "West Virginia"]	

BUREAU V. 2

JUL 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07643
214

07666

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M r y l a n d b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Glenn			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Walter Reed Annex				d. STREET ADDRESS 1902 Wilcher Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jack Middle F. Last Lindley				4. DATE OF DEATH Month July Day 1 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/1918		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months 38 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M. Sgt.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W Lindleys				14. MOTHER'S MAIDEN NAME Ollie McKay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 238-05-9615		17. INFORMANT Army records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/1/57	
EXAMINER'S NAME (Type) Fr ank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-3-57		22c. NAME OF CEMETERY OR CREMATORY Wash D.C. 1400 Chapin St		22d. LOCATION (City, town, or county) (State) CHARLOTTE, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 1400 Chapin St		24a. REC'D BY REGISTRAR 5 24b. REGISTRAR'S SIGNATURE Lancee Petty	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES M. HANLEY		45		Male		White		July 3, 1957		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASES PRESENT		DISEASES PRESENT	
1000 North Caroline		Police Officer		Heart Disease		Natural		Coronary Atherosclerosis		Hypertension	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF EXAMINATION		TIME OF EXAMINATION		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
July 5, 1957		10:00 AM		JAMES M. HANLEY		JAMES M. HANLEY		JAMES M. HANLEY		JAMES M. HANLEY	

RECEIVED
 JUL 5 1957
 BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07644

Reg. Dist. No.

223

07569

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring d. STREET ADDRESS 600 Dale Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Llewellyn Last Lowery				4. DATE OF DEATH Month July Day 13 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-15-93	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 4		IF UNDER 24 HRS. Hours 1 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? America							
13. FATHER'S NAME Charles Nicholas Lowery				14. MOTHER'S MAIDEN NAME Mary Ann Devore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 420.1		17. INFORMANT (Wife) Rhea G. Lowery (Son)		Address 600 Dale Dr. S. S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (c) 420.1 DUE TO (a) 420.1 (b) 420.1 (c) 420.1							INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 hr							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-13-57	
EXAMINER'S NAME (Type) FRANK J. Broschert				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 15, 1957		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FINGERPRINTS (Director's Signature)		ADDRESS 259 Carroll St.		24a. RECEIVED BY REGISTRAR 7/15/57		24b. REGISTRAR'S SIGNATURE William D. Bell	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

Wm. D. Davis 2nd Curator

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 11 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 Granville Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY (Nmi) LUCAS				4. DATE OF DEATH July 28 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker				10b. KIND OF BUSINESS OR INDUSTRY Ladies Apparel		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Stanislaw Doboziński				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 017-12-1714A			
17. INFORMANT Chester F. Bernard				Address 200 Granville St., SS., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastasis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 January 1957 , to 28 July 1957 , that I last saw the deceased alive on 28 July 1957 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 929 Pershing Drive, Silver Spring, Md. DATE SIGNED 29 July 57							
ACTUAL SIGNATURE Seruch T. Kimble M.D.							
PHYSICIAN'S NAME (Type) SERUCH T. KIMBLE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Forest Glen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harner G. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR 7/30/57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07592

CERTIFICATE OF DEATH

07646

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanatorium</u>				d. STREET ADDRESS <u>3747-Jessie St., NW</u>			
3. NAME OF DECEASED (Type or print) <u>Nettie E Lyon</u>				4. DATE OF DEATH <u>July 6th 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/10/1870</u>	
9. AGE (In years on birthday) <u>86</u> yrs.		IF UNDER 1 YEAR <u>8</u> Months <u>26</u> Days		IF UNDER 24 HRS. <u>19</u> Hours <u>57</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel S. Lyon</u>				14. MOTHER'S MAIDEN NAME <u>Addie J. Lyon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Robert J. Lyon (Brother)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>433.1 Atrial fibrillation</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>Oct. 22nd, 1947</u> , to <u>July 6th, 1957</u> , that I last saw the deceased alive on <u>July 5th, 1957</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>716/57</u> DATE SIGNED ACTUAL SIGNATURE <u>W. L. Roy Dunn</u> M.D. <u>1150 Canal Ave</u> PHYSICIAN'S NAME (Type) <u>Washington 6 D.C.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>7/8/1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u> 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN W. EYSONG COMPANY</u> ADDRESS <u>1300 N. STREET, N.W. WASHINGTON, D.C.</u> 24a. REC'D BY REGISTRAR <u>JUL 8</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Lawrence Hayter</u>							

BUREAU V. S.

1957 8 701

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G218 8-6-57 et
07570
CERTIFICATE OF DEATH

07647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PK</u>		c. LENGTH OF STAY IN 1b <u>5 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home</u>		e. STREET ADDRESS <u>4408 30th ST</u>	
3. NAME OF DECEASED (Type or print) <u>LAYENIA</u> First <u>T</u> Middle <u>MAINTOSH</u> Last		4. DATE OF DEATH <u>JULY</u> Month <u>27</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 11 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralph Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>392X</u>	
17. INFORMANT <u>Mrs Isabelle Cox</u> Address <u>4408 30th St, Mt Rainier Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART BLOCK WITH CARDIAC ARREST</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Generalized Arteriosclerosis</u> (c) <u>5 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8 years</u> <u>Cerebral Thrombosis, old.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>APRIL 1952</u> to <u>JULY 27, 1957</u> , that I last saw the deceased alive on <u>JULY 27, 1957</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Norman Dorat Pomeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3513 Penny St</u> DATE SIGNED <u>7/27/57</u>	
PHYSICIAN'S NAME (Type) <u>Norman Dorat Pomeau</u>		<u>MT RAINIER MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u>		ADDRESS <u>Mt Rainier MD</u>	
24a. REC'D BY REGISTRAR <u>J. H. H. H. H.</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>	
DATE <u>JUL 31 1957</u>			

BUREAU V. S.

JUL 31 1957

RECEIVED

07668

CERTIFICATE OF DEATH

07648

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY AA.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5 Alder Road			
3. NAME OF DECEASED (Type or print) First Stephen Middle Frances Last MALICKI				4. DATE OF DEATH Month July Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-3-55	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Tadeus Malicki				14. MOTHER'S MAIDEN NAME Claire Clarke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mother, Claire Malicki (Same As #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Neuroblastoma 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 months DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 16 June , 19 57 , to 8 July , 19 57 , that I last saw the deceased alive on 8 July , 19 57 , and that death occurred at 3:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-9-57							
ACTUAL SIGNATURE John H. Mazur M.D.							
PHYSICIAN'S NAME (Type) JOHN H MAZUR, LT. MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-10-57		22c. NAME OF CEMETERY OR CREMATORY Annapolis Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons, Annapolis, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 7-9-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Russell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07669

CERTIFICATE OF DEATH

Reg. Dist. No. 215

07649

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 43 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701-4			
f. STREET ADDRESS 715 Highwood Drive				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Thomas Last MANNION				4. DATE OF DEATH Month July Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1897		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas P. MANNION				14. MOTHER'S MAIDEN NAME Delia GILLESPIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I & II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X Pneumonia						INTERVAL BETWEEN ONSET AND DEATH Indef	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 June , 19 57 , to 23 July , 19 57 , that I last saw the deceased alive on 22 July , 19 57 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. ACTUAL SIGNATURE R. Im. Carby M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 July 1957		22c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Liston Wiederfield, Greenmount & 22nd				24a. REC'D BY REGISTRAR DATE 7-23-57		24b. REGISTRAR'S SIGNATURE May E. Parrelly	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07670

CERTIFICATE OF DEATH

Reg. Dist. No.

07650

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS 9 Cargo Green		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maria Middle San Nicholas Last MATEO				4. DATE OF DEATH Month July Day 13 Year 1957			
5. SEX Female		6. COLOR OR RACE Maylayan		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 26, 1921	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months 36 Days 36 Hours 36 Min. 36		IF UNDER 24 HRS. Months 36 Days 36 Hours 36 Min. 36		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Anesthetist	
10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Guam		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Pedro C. MATEO				14. MOTHER'S MAIDEN NAME Rosa ALVERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Brother, Juan San Nicholas MATEO (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIC ACIDOSIS 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) HYPERTENSION, ARTERIAL, MALIGNANT (c) POSSIBLE CHRONIC GLOMERULONEPHRITIS						INTERVAL BETWEEN ONSET AND DEATH 3 WKS 7 YRS 3 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 445X						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 1957 to July 13, 1957 that I last saw the deceased alive on July 13, 1957 and that death occurred at 5:26 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-14-57							
ACTUAL SIGNATURE <i>William B. Ingram</i> M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) William B. INGRAM, CDR MC USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Pigo, Guam (Marianas Islands)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda Md				24a. REC'D BY REGISTRAR DATE 7-15-57		24b. REGISTRAR'S SIGNATURE <i>Mary E. Parelly</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED HARRISON (MRS.)		MAYMOR	
DATE OF DEATH 1957 JUL 19		PLACE OF DEATH HOME	
AGE 68		SEX F	
RACE W		EDUCATION H	
BIRTH DATE 1889		BIRTH PLACE MD	
MARRIAGE DATE 1910		MARRIAGE PLACE MD	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE HEART DISEASE		MANNER OF DEATH NATURAL	
UNDERLYING CAUSE HEART DISEASE		CERTIFICATE NO. 12345	
DATE OF DEATH 1957 JUL 19		PLACE OF DEATH HOME	
AGE 68		SEX F	
RACE W		EDUCATION H	
BIRTH DATE 1889		BIRTH PLACE MD	
MARRIAGE DATE 1910		MARRIAGE PLACE MD	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE HEART DISEASE		MANNER OF DEATH NATURAL	
UNDERLYING CAUSE HEART DISEASE		CERTIFICATE NO. 12345	

RECEIVED
JUL 19 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07651

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2710 Fenimore Rd</u>				d. STREET ADDRESS <u>2710 Fenimore Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pearse</u> Middle <u>Mary</u> Last <u>May</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-01</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm H. Woodward</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Sommer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Joe May (husband)</u> Address <u>Apn 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>COLUMBIA GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u>				ADDRESS <u>4812 GAULE WASH DC</u>		24a. REC'D BY REGISTRAR <u>JUL 8</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Potter</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt exists as to the cause of death, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07672

CERTIFICATE OF DEATH

07652

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS N.W. 4000 Massachusetts Avenue,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ivy Middle Amelia Last MC CULLOUGH				4. DATE OF DEATH Month July Day 4 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 24, 1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min.		IF UNDER 24 HRS. Months 53 Days 53 Hours 53 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife			
11. BIRTHPLACE (State or foreign country) Illinois				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Oscar MEYER				14. MOTHER'S MAIDEN NAME Lilly GRIEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT (Husband) Harry Ross MC CULLOUGH				Address (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 157X DUE TO + widespread Pulmonary metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic failure due to metastases						INTERVAL BETWEEN ONSET AND DEATH 4 days 3 months 9 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 11, 1957 to July 4, 1957 , that I last saw the deceased alive on July 4, 1957 , and that death occurred at 8:05 A.M. from the causes and on the date stated above. George W. Russell ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-4-57							
ACTUAL SIGNATURE George W. Russell M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) George W. RUSSELL, CAPT, MC, USN/ U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-5-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS 5557 Wisc. Ave., Bethesda, Md.				24. REC'D BY REGISTRAR Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		Male		White		1892		Baltimore		Maryland		Maryland		United States	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Married		1915		Baltimore		Maryland		Maryland		United States		1957		Baltimore		Maryland	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Physician		1950		Baltimore		Maryland		Maryland		United States		1957		Baltimore		Maryland	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Heart Disease		1957		Baltimore		Maryland		Maryland		United States		1957		Baltimore		Maryland	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH		STATE OF MANNER OF DEATH		COUNTRY OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Natural		1957		Baltimore		Maryland		Maryland		United States		1957		Baltimore		Maryland	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. Harris		1957		Baltimore		Maryland		Maryland		United States		1957		Baltimore		Maryland	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. Harris		1957		Baltimore		Maryland		Maryland		United States		1957		Baltimore		Maryland	

BUREAU V. E.

JUL 8 1957

RECEIVED

07571

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Silver Spring b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 948 B Northampton Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William Perry McManaway				4. DATE OF DEATH Month July Day 24 Year 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-28-14	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pressman				10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Charles McManaway				14. MOTHER'S MAIDEN NAME Emma Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 277-03-5827		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Disease & Heart Surgery DUE TO (c) 2 yrs ago PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death Terminal-1 hr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/24 , 19 57 , to 7/24 , 19 57 , that I last saw the deceased alive on 7/24 , 19 57 , and that death occurred at 6:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Hare M.D.				ADDRESS (Street, city or town, state) Takoma Park, Md. DATE SIGNED 7/24/57			
PHYSICIAN'S NAME (Type) Robert A. Hare M.D.				Released by Dr. Ball-Cornwall			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Ship & burial		7/24/57		Midway Cemetery		Midway, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Campbell				24. REG'D BY REGISTRAR 2434 DATE JUL 25 1957			
25. REGISTRAR'S SIGNATURE John D. Ball							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		1922		MEMPHIS, TENN		JUL 6, 1968		MEMPHIS, TENN		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07654

07673

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY M ontgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b 20 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK First W, Middle Mc. REYNOLDS Last		4. DATE OF DEATH July Month 6 Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. II 1871
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer	11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lafayette Emerson Mc.Reynolds	
14. MOTHER'S MAIDEN NAME Mary Bell Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ### (If yes, give branch or dates of service) #####	
16. SOCIAL SECURITY NO. None		17. INFORMANT Jessie B. McReynolds Address Sandy Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Enterococcal Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 May , 19 57 , to 6 July , 19 57 , that I last saw the deceased alive on 6 July , 19 57 , and that death occurred at 10:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE C.H. LIGON		ADDRESS (Street, city or town, state) Sandy Spring Md. DATE SIGNED 7/8/56	
PHYSICIAN'S NAME (Type) C.H. LIGON		M.D. Sandy Spring Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 10	Friends Cent	Sandy Spring Md.
23. FUNERAL DIRECTOR'S SIGNATURE ROY W. BARBER		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR 8-10-57		24b. REGISTRAR'S SIGNATURE Lestride B. Lowry	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07655

Reg. Dist. No. 216

07674

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY White Plains	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains 698-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3112 Ieland St.		d. STREET ADDRESS 4 Hilton Ave.	
3. NAME OF DECEASED (Type or print) Robert Stanton Merithew		4. DATE OF DEATH July 4, 1957 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR: Months 52 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive engineer		10b. KIND OF BUSINESS OR INDUSTRY N.Y.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME A. Floyd Merithew		14. MOTHER'S MAIDEN NAME Gertrude P. Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 023-05-7810	
17. INFORMANT Mrs. Geo. R. Titus (sister)		Address Item 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 7/5/57	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR 7-5-57		24b. REGISTRAR'S SIGNATURE Beattie M. Thompson	

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CERTIFICATE OF DEATH

07656

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 8009 Custer Road			
3. NAME OF DECEASED (Type or print) First Richard Middle Norman Last MEYER				4. DATE OF DEATH Month July Day 29 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 November 1910	
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Phillip C. MEYER				14. MOTHER'S MAIDEN NAME May Hyman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Madeleine C. Meyer (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 162X IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with generalized metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH indefinite						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 24 July , 19 57 , to 29 July , 19 57 , that I last saw the deceased alive on 29 July , 19 57 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 7-29-57							
ACTUAL SIGNATURE J. T. Horgan				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) J. T. HORGAN, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 August 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 7-29-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Farrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
C7676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07657
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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 1 year			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,007 Loraine Ave.				d. STREET ADDRESS 4918 3rd St., N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HELEN Middle HOWARD Last MILLER				4. DATE OF DEATH Month JULY Day 11 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1899		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IBM Operator - Government Services, Inc.			10b. KIND OF BUSINESS OR INDUSTRY HOWARDVILLE, VIRGINIA		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME ARTHUR W. STUDDS				14. MOTHER'S MAIDEN NAME ANNA E.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-10-7219		17. INFORMANT Address Mr. Farnham R. Miller, 10,007 Loraine Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/11/57	
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/15/57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 7-17-57	
				24b. REGISTRAR'S SIGNATURE Francis Miller			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF BIRTH		CITY OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL DATA	
FAMILY HISTORY		SOCIAL HISTORY		PERSONAL HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
POSTMORTEM EXAMINATION		GROSS FINDINGS		MICROSCOPIC FINDINGS		TOXICOLOGICAL FINDINGS		OTHER FINDINGS	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF SIGNATURE		PLACE OF SIGNATURE		OFFICE OF EXAMINER	

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 JUL 19 1957
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07658

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Washington b. COUNTY Dist. of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont			c. LENGTH OF STAY IN 1b ??	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) C & O Canal				d. STREET ADDRESS 620 E Street, S. W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Morton Middle Ray Last MILLER		4. DATE OF DEATH Month July Day 7 Year 19 57					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/41		9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months 9 Days 21	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Miller			14. MOTHER'S MAIDEN NAME Alice William				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Alice Teresi- Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO (b) Drowning Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 9298		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) apparently drowned while swimming in Canal					
20c. TIME OF INJURY Month, Day, Year ? Hour o. m. 7/7/ 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) C & O Canal		20f. (City or town) (County) (State) Brookmont Montg. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		July 8, 1957	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 7/12/57		24b. REGISTRAR'S SIGNATURE <i>Gertrude Lawler</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

...MEDICAL EXAMINER'S CERTIFICATE OF DEATH...
...MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JUL 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07659
218

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b 6Mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Marylander Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pearl Middle M. Last Mills		4. DATE OF DEATH Month July Day 29 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10-1979
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 19 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Snow Hill, Md		12. CITIZEN OF WHAT COUNTRY? md	
13. FATHER'S NAME George S. Miller		14. MOTHER'S MAIDEN NAME Mattie Nash	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary Black		Address 4529 S. Lehigh Ave. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 730.3 Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/10 , 19 57 , to 7/29 , 19 57 , that I last saw the deceased alive on 7/26 , 19 57 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Winnings, Md. DATE SIGNED 7/29/57	
PHYSICIAN'S NAME (Type) James P. Kerr			
22a. BURIAL, CREMATION, ETC. (Specify) Burial		22b. DATE THEREOF 7-31-57	
22c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist		22d. LOCATION (City, town, or county) (State) Snow Hill, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Clay E. Dennis		24a. REC'D BY REGISTRAR NOV 1 1957 24b. REGISTRAR'S SIGNATURE Alvorda Cook	

3.4 OUTLINE

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DECEMBER

BUREAU V. S.

1957 1 AUG

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07572

CERTIFICATE OF DEATH

07660

Reg. Dist. No.

773

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK. MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fair Hill Rest Home 207 HUDSON AVENUE				d. STREET ADDRESS 1852 Columbia Rd. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATHERINE Middle G. Last MIXER				4. DATE OF DEATH Month 7 Day 5 Year 1957			
5. SEX Female		6. COLOR or RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1873 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 84 yrs.	
11. BIRTHPLACE (State or foreign country) Evansville, Indiana				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Bradley Graham				14. MOTHER'S MAIDEN NAME Elizabeth M. Gooldy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Winifred H. Johnson		Address 1852 Columbia Rd. Washington, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 minutes 5 years						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1950 to July 5, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 6:45 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Horace H. Custis, Jr.				ADDRESS (Street, city or town, state) 1852 Columbia Rd. N. W. DATE SIGNED 7/5/57			
PHYSICIAN'S NAME (Type) Horace H. Custis, Jr.				1852 Columbia Rd. N. W.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/57		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company				ADDRESS Washington, DC		24a. REC'D BY REGISTRAR JUL 8 1957	
24b. REGISTRAR'S SIGNATURE J. Hines							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED	

BUREAU V. 2

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07661

7679

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 2 hr. 36 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS Spencerville X 2			
3. NAME OF DECEASED (Type or print) (Girl) MOODY				4. DATE OF DEATH July 13 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/57	
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 36		11. IF UNDER 24 HRS. 36		12. CITIZEN OF WHAT COUNTRY? United States	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
13. FATHER'S NAME Robert A. Moody				14. MOTHER'S MAIDEN NAME Anne Shirley Gardner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Anne Shirley Moody Address Spencerville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aklectasia (new born) 762.5 DUE TO prematurity, 28 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prematurity, 28 weeks (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on July 13 , 19 57 , and that death occurred at 4:00 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Bertram D. Law M.D. Spencerville Maryland 7-13-57 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF July 15/57		22c. NAME OF CEMETERY OR CREMATORY Union Burial Home Spencerville Md	
22d. LOCATION (City, town, or county) (State) Spencerville Md				24a. REC'D BY REGISTRAR 7/16/57			
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber ADDRESS Spencerville Md				24b. REGISTRAR'S SIGNATURE Bertram D. Law			

22073245XVI

CERTIFICATE OF DEATH

517

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. Includes a large diagonal line across the middle and a signature at the bottom.

BUREAU V. E.

JUL 23 1957

RECEIVED

7/10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07680

CERTIFICATE OF DEATH

07662
Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville <i>x2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First (Baby Girl) Middle Moody Last Moody				4. DATE OF DEATH Month July Day 21 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13 1957	
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min. 9		10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) #####		10b. KIND OF BUSINESS OR INDUSTRY #####	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U,S,A,			
13. FATHER'S NAME Robert A. Moody				14. MOTHER'S MAIDEN NAME Anne Shirley Gardner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ##		16. SOCIAL SECURITY NO. (If yes, ## or dates of service) ###		17. INFORMANT Address Robert A. Moody Spencerville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774X blood dyscrasia + malnutrition DUE TO (b) prematurity (28 weeks) DUE TO (c) 774X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-13-1957 to 7-21-1957 , that I last saw the deceased alive on 7-20-1957 , and that death occurred at 2:48 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SYKESVILLE Maryland DATE SIGNED 7/31/57							
ACTUAL SIGNATURE Burton R. Gau				M.D. SYKESVILLE Maryland			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23 57		22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Burtonsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Boyd W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE 7-23-57	
				24b. REGISTRAR'S SIGNATURE Burton R. Gau			

2173244 XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07663

07681

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 17 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Granville Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frances Zimmerman Moore				4. DATE OF DEATH July 24 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 23, 1893	
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)				10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Paola, Kansas	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George W. Zimmerman				14. MOTHER'S MAIDEN NAME Laura J. Scaritt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 4 hrs 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis 10 yrs DUE TO (c) Hypertension 15 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 15, 1957 to July 23, 1957 , that I last saw the deceased alive on July 18, 1957 , and that death occurred at 3:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1714 R.I. Ave NW DATE SIGNED ACTUAL SIGNATURE Arthur H. Lewis M.D. WASHINGTON DC PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George's Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey				24a. REC'D BY REGISTRAR DATE 7-25-57		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. HENNESSY		Male		30		1927		New York		New York		New York		U.S.A.	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS	
Salesman		High School		Catholic		Married		Natural		Heart Disease		Coronary Artery Disease		Sudden	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL		CITY	
July 29, 1957		New York		New York		New York		U.S.A.		July 30, 1957		New York		New York	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF JURY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JUL 29 1957
BUREAU V. S.

(7682

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 4TX-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital		d. STREET ADDRESS 2938 MCKINLEY ST. NW	
3. NAME OF DECEASED (Type or print) First GEORGE Middle EARNEST Last MOORE		4. DATE OF DEATH Month JULY Day 24 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 24-1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISPLAY DEPT.		10b. KIND OF BUSINESS OR INDUSTRY DRUG STORE	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ANTHONY BURTON MOORE		14. MOTHER'S MAIDEN NAME JOHANNA AGUSTA AMREIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-05-5160	
17. INFORMANT ELSIE MOORE - WIFE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Artery Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days 2-3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 610x Post-Prostatectomy - 3 weeks		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 17, 1957 to July 24, 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5516 Webster Ave DC DATE SIGNED 7-24-57			
ACTUAL SIGNATURE Robert B. Havell		M.D. 5516 Webster Ave DC	
PHYSICIAN'S NAME (Type) Robert B. Havell			
22a. BURIAL, CREMATION, REASONALITY burial		22b. DATE THEREOF 7/27/57	
22c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Park Cemetery		22d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		ADDRESS Wash, DC	
24a. REC'D BY REGISTRAR JUL 25 1957		24b. REGISTRAR'S SIGNATURE Reside Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF MINISTER		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR		21. SIGNATURE OF SHERIFF		22. SIGNATURE OF TOWNSHIP CLERK		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF STATE CLERK	

RECEIVED
JUL 25 1957
BUREAU V. 3

07683

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 835 Florida Avenue, N. E.	
3. NAME OF DECEASED (Type or print) First Herbert Middle Powell Last Murphy		4. DATE OF DEATH Month July Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1902
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Laborer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Murphy		14. MOTHER'S MAIDEN NAME Mary C. Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erosion of esophageal blood vessel by Carcinoma 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Esophagus with metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs 8 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 7 , 19 57 , to July 17 , 19 57 , that I last saw the deceased alive on July 17 , 19 57 , and that death occurred at 5:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 7/17/57 National Institutes of Health Bethesda 14, Maryland		
ACTUAL SIGNATURE Theodore Robinson, M. D.		
PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
Burial	7-22-57	Lincoln Mem
23. FUNERAL DIRECTOR'S SIGNATURE Tracy's Funeral Home		24a. REC'D BY REGISTRAR JUL 22 1957
ADDRESS 389 R I Ave NW		24b. REGISTRAR'S SIGNATURE Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF CORONER	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF TOWNSHIP CLERK		25. SIGNATURE OF COUNTY CLERK	

BUREAU V. 3

JUL 22 1957

RECEIVED

07684

CERTIFICATE OF DEATH

07666

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 23hr.40 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5 Cargo Green, S.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Jude Last MURPHY				4. DATE OF DEATH Month July Day 29 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 July 1957		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months 23 Days 40	IF UNDER 24 HRS. Hours 23 Min. 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Paul Vincent MURPHY				14. MOTHER'S MAIDEN NAME Joyce Elaine BOLGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Paul V. MURPHY (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 23hr 40min (c) Immaturity				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 July , 19 57 , to 29 July , 19 57 , that I last saw the deceased alive on 29 July , 19 57 , and that death occurred at 11:50P M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.				DATE SIGNED 7-30-57			
ACTUAL SIGNATURE Russell Miller, Jr.				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Russell Miller, Jr., LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-31-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				24a. REC'D BY REGISTRAR 7-30-57		24b. REGISTRAR'S SIGNATURE Harry E. Parrelly	
R.A. Humphrey, 7551 Wisconsin Ave., Bethesda, Md.							

205/304XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HENRY		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 1912	
5. PLACE OF BIRTH BOSTON, MASS.		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF DEATH Aug 1, 1957	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease	
11. MEDICAL HISTORY Hypertension		12. SIGNATURE OF PHYSICIAN J. J. Smith	
13. SIGNATURE OF REGISTRAR J. J. Smith		14. SIGNATURE OF DECEASED J. J. Henry	

RECEIVED
AUG 1 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07573

CERTIFICATE OF DEATH

07667
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 3 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Christianson's Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lepha Estelle Neely				4. DATE OF DEATH July 16 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1877	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) St. Joseph, Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jacob Coons				14. MOTHER'S MAIDEN NAME Martha Freeman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Wm. H. Neely, 10,032 Dallas Ave., Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 450 (b) Senile Arteriosclerosis Generalized DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pressure Necrosis of Hip and both Heels.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 9 p. m. Month, 19 Day, 19 Year, 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 15 1957 to July 16 1957 , that I last saw the deceased alive on July 15 1957 , and that death occurred at 8:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. B. Queen				ADDRESS (Street, city or town, state) 7112 Willow Ave Takoma Park, Md			
PHYSICIAN'S NAME (Type) J. B. QUEEN				DATE SIGNED 17 July 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner Co. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR 7/19/57	
				24b. REGISTRAR'S SIGNATURE F. Nelson Dodd			

CERTIFICATE OF DEATH

NAME OF DECEASED Mrs. Elizabeth J. [illegible]		SEX Female		AGE 72		DATE OF BIRTH Jan. 20, 1877		PLACE OF BIRTH [illegible]	
OCCUPATION [illegible]		MARITAL STATUS Married		PLACE OF DEATH [illegible]		DATE OF DEATH [illegible]		TIME OF DEATH [illegible]	
CAUSE OF DEATH [illegible]		MEDICAL HISTORY [illegible]		PRESENT ILLNESS [illegible]		DATE OF ONSET [illegible]		DATE OF LAST EXAMINATION [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF REGISTRAR [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]	

BUREAU V. E.

JUL 22 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07668

07685

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Peter Last Nehouse		4. DATE OF DEATH Month July Day 1 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/84
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Nehouse	
14. MOTHER'S MAIDEN NAME Annie Hager		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-01-1707		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Left Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 year +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 7/2/57			
ACTUAL SIGNATURE G. F. Meadors, Jr. M.D. _____			
PHYSICIAN'S NAME (Type) G. F. Meadors, Jr., M. D. Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1957	
22c. NAME OF CEMETERY OR CREMATORY Salem Methodist		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molsworth		24a. REC'D BY REGISTRAR DATE 7-6-57	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Katherine B. Lawler	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
Maryland		Male		3 days		Caucasian		None	
6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
Maryland		Maryland		July 12, 1957		10:00 AM		Sudden	
11. NAME OF PHYSICIAN		12. NAME OF HOSPITAL		13. NAME OF NURSE		14. NAME OF ATTENDING PHYSICIAN		15. NAME OF CORONER	
None		None		None		None		None	
16. NAME OF FUNERAL HOME		17. NAME OF BURIAL PLACE		18. NAME OF CEMETERY		19. NAME OF INTERMENT		20. NAME OF INTERMENT	
None		None		None		None		None	

BUREAU V. 3

JUL 12 1957

RECEIVED

Item 1 Film G217 7-16-57 et
07686 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07669
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6425 Kenhowe Drive, Bethesda				d. STREET ADDRESS 6425 Kenhowe Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) WILLIAM First NEWTON Middle Last				4. DATE OF DEATH July 4, 1957 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1865	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Miner		11. BIRTHPLACE (State or foreign country) Manchester, England		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Newton				14. MOTHER'S MAIDEN NAME Sarah Davies			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 420.0		17. INFORMANT Mrs. Dorothy Rizzo, 6425 Kenhowe Drive, Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH 3 hrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 25, 1957 to July 4, 1957 that I last saw the deceased alive on July 25, 1957 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I Donovan M.D.				ADDRESS (Street, city or town, state) 5016 GEORGETOWN RD BETHESDA MD			
DATE SIGNED 7/4/57							
PHYSICIAN'S NAME (Type) LEO I DONOVAN M.D.				BETHESDA MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY Neshaminy Rd		22d. LOCATION (City, town, or county) (State) Bethesda, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Cheng Phao Fong Home				ADDRESS 5103 Wisc Ave N.W. Wash D.C.		24a. REC'D BY REGISTRAR 7-8-57	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

JUL 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07670

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>7800 Marion Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Smithdeal</u> Last <u>Norman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/22/1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Smithdeal</u>		14. MOTHER'S MAIDEN NAME <u>Laura Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subdural hematoma & cerebral laceration</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps</u>	
20c. TIME OF INJURY Month, Day, Year <u>1.00</u> <u>7/16/57</u> Hour <u>0000</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Bethesda Montg. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>7/29/57</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>7/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24. REC'D BY REGISTRAR <u>7-29-57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 1 1957
BUREAU V. S.

Examination 7/29/57 Cedar Hill
Robert J. Thompson - Bethesda, Md.

(7688)

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 Mo. 6 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 3343 Nichols Ave., S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cornelius Middle Edward Last O'BRIEN				4. DATE OF DEATH Month July Day 22 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 November 1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Patrick O'BRIEN				14. MOTHER'S MAIDEN NAME Mary Sugrue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 147X Intracranial metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma right parietal 14 mos. DUE TO (c) sinus (larynx)				INTERVAL BETWEEN ONSET AND DEATH 30 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 17 June 1957				20g. (County) 22 July 1957		20h. (State) 1:35P. M.	
21. I certify that I attended the deceased from 17 June 1957 to 22 July 1957 , that I last saw the deceased alive on 22 July 1957 , and that death occurred at 1:35P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Blair M. Webb				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 7-23-57							
PHYSICIAN'S NAME (Type) Blair M. Webb, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines				ADDRESS 2901 14th St., NW, Washington, D.C.		24a. REC'D BY REGISTRAR 7-23-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1892		BALTIMORE		MD		U.S.A.	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
1234 E. BALTIMORE ST.		JUL 24 1957		BALTIMORE		MD		U.S.A.		JUL 26 1957		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU. V. S.

JUL 24 1957

RECEIVED

Item 9 FilmG218 7-29-57 et

07689

CERTIFICATE OF DEATH

07672

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium & Hospital</u>				d. STREET ADDRESS <u>15517 Hoover St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Frances</u> Last <u>O'Neill</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 Sept 1881</u>		9. AGE (In years lost birthday) <u>75 1/2</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward J. O'Neill</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET GALIVAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARY USILTON</u> Address <u>5517-HOOVER ST</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident (Thrombosis)</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>Dissect</u> (c) <u>> 10 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 21</u> , 19 <u>57</u> , to <u>July 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>57</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Habeeb Bacchus</u> M.D. <u>1746 K Street, N.W. Wash. D.C.</u> <u>7/21/57</u>							
PHYSICIAN'S NAME (Type) <u>HABEEB BACCHUS</u> (Patient has been seen by <u>Dr. W. Angermue previously</u>) Suite 62. DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>Wash. D.C. 14th. St. N.W.</u>				24a. REC'D BY REGISTRAR <u>JUL 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

JUL 22 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

07574

07673
07613
223

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>			
c. LENGTH OF STAY IN 1b <i>7 1/2 days</i>				d. STREET ADDRESS <i>17603 Central Ave.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Arthur</i> Middle <i>George</i> Last <i>Parks</i>				4. DATE OF DEATH Month <i>July</i> Day <i>19</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 21, 1900</i>	
9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>							
13. FATHER'S NAME <i>Perry Parks</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ann Louderstein</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rocky Mountain Spotted Fever</i> 104.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>7/12</i> , 19 <i>57</i> , to <i>7/19</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7/18</i> , 19 <i>57</i> , and that death occurred at <i>2:30</i> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Raymond O. West</i>				ADDRESS (Street, city or town, state) <i>7600 Carnegie Ave Tak. Md.</i> DATE SIGNED <i>7/19/57</i>			
PHYSICIAN'S NAME (Type) <i>RAYMOND O. WEST.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 22, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Johnstown, Penna.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Shultz</i>				ADDRESS <i>254 Carmel St. N.W. Takoma Park D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>8/20/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. Wilson Dodd</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF BIRTH		10. MARITAL STATUS	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF NEAREST RELATIVE	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF OTHER	
21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER	
23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER	
27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER	
35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER	
39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER	
45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER	
47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER	
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57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER	
59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER	
63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER	
65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER	
69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
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73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER	
75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER	
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79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
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83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER	
87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER	
89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER	
95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER	
99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

RECEIVED
JUL 22 1957
BUREAU V. S.

07575

CERTIFICATE OF DEATH

Reg. Dist. No.

7X3

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before, admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		d. STREET ADDRESS <u>7108 Maple Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>MANNETTE BEADOCK</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife, Clerk, Dept. Stores.</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Falston FOSTER</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>581.0 Fatty Liver</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 31, 1957</u> to <u>July 31, 1957</u> , that I last saw the deceased alive on <u>July 31, 1957</u> , and that death occurred at <u>4:58 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7625 Carroll Ave, Takoma Park, Md</u> DATE SIGNED <u>Aug 1/57</u>			
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D.		PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-5-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASH NATL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co</u> ADDRESS <u>5801 - Cleveland Ave</u>			
24a. REG'D BY REGISTRAR <u>DATE 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18-001-114

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>1910</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. PLACE OF DEATH <i>Home</i>	
9. DATE OF DEATH <i>Aug 5, 1957</i>		10. TIME OF DEATH <i>10:15 AM</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
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39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07576 CERTIFICATE OF DEATH

07675

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 17 TAKOMA PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 800 HAYWARD AVENUE				d. STREET ADDRESS 800 HAYWARD AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILDRED Middle MARIE Last PEAKE			4. DATE OF DEATH Month JULY Day 6 Year 19 57				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/94		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN KOONTZ				14. MOTHER'S MAIDEN NAME THERESA DONOVAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Donald F. Peake, 12,332 Centerhill St. Wheaton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary failure 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis DUE TO (c) to severe debilitation							INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 5 years 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 Arteriosclerotic heart disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. 9 p. m. Month, Day, Year 19 57			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 19 57 , to July 6 , 19 57 , that I last saw the deceased alive on July 3 , 19 57 , and that death occurred at 3:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Coleman MD			ADDRESS (Street, city or town, state) 113 Carroll St NW Washington 12 DC			DATE SIGNED 7/6/57	
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/10/57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 7/10/57	
				24b. REGISTRAR'S SIGNATURE J. Wilson Dodd			

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. ROY		AGE 45		SEX M		RACE W		DATE OF BIRTH JUL 11 1912		PLACE OF BIRTH BALTIMORE, MD	
MANNER OF DEATH NATURAL		CAUSE OF DEATH CORONARY THROMBOSIS		IMMEDIATE CAUSE HEART FAILURE		DISEASE OR INJURY CORONARY ARTERY DISEASE		PERIOD OF ILLNESS 2 WEEKS		PLACE OF DEATH HOME	
DATE OF DEATH JUL 11 1957		TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME		NAME OF PHYSICIAN DR. J. J. ROY		NAME OF HOSPITAL BALTIMORE HOSPITAL		NAME OF NURSE J. J. ROY	
NAME OF FUNERAL HOME J. J. ROY		NAME OF CEMETERY BALTIMORE CEMETERY		NAME OF MINISTER J. J. ROY		NAME OF CHURCH BALTIMORE CHURCH		NAME OF CLERGYMAN J. J. ROY		NAME OF CLERGYMAN J. J. ROY	

BUREAU V. 3

JUL 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07676

67690

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Lebanon b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 192 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beirut			
3. NAME OF DECEASED (Type or print) First Helen Middle Vantrease Last Phelps				4. DATE OF DEATH Month July Day 1 Year 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas H. Vantrease				14. MOTHER'S MAIDEN NAME Sarah McMillen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO ? Respiratory Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Care of Breast Metastatic to Lungs Liver Bones (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 21, 1956 to July 1, 1957 , that I last saw the deceased alive on July 1, 1957 , and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/1/57							
ACTUAL SIGNATURE Arthur J. Garceau M.D.				PHYSICIAN'S NAME (Type) Arthur J. Garceau, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF July 1 1957		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		22d. LOCATION (City, town, or county) (State) SMITHLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Cheryl Chase Funeral Home Wash DC				24a. REC'D BY REGISTRAR DATE 7-8-57		24b. REGISTRAR'S SIGNATURE Bennie M Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1. NAME OF DECEASED Thomas H. Harrison		2. SEX Male		3. AGE 70	
4. RACE White		5. DATE OF BIRTH January 23, 1887		6. PLACE OF BIRTH Baltimore, Maryland	
7. OCCUPATION None		8. PRESENT ADDRESS The Clinical Center, Bethesda, Md.		9. DATE OF DEATH July 1, 1957	
10. CAUSE OF DEATH Myocardial infarction		11. PLACE OF DEATH The Clinical Center, Bethesda, Md.		12. SIGNATURE OF REGISTRAR [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF PHYSICIAN [Signature]	

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JUL 10 1957

RECEIVED

1. This certificate is required by law to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. It is the duty of the person having knowledge of the death to file this certificate. If the death is not reported, the Registrar will cause a search to be made for the death. If the death is not reported, the Registrar will cause a search to be made for the death. If the death is not reported, the Registrar will cause a search to be made for the death.

CERTIFICATE OF DEATH

NAME OF DECEASED Robert A. Pumphrey		DATE OF BIRTH July 31, 1917		PLACE OF BIRTH Baltimore, Maryland	
MARRIAGE Married		DATE OF MARRIAGE June 1, 1941		PLACE OF MARRIAGE Baltimore, Maryland	
OCCUPATION Government		EDUCATION High School		RELIGION Roman Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Baltimore, Maryland	
DATE OF DEATH August 1, 1957		TIME OF DEATH 11:57 AM		PLACE OF DEATH Baltimore, Maryland	
SIGNATURE OF PHYSICIAN J. Edgar Smith		SIGNATURE OF DECEASED Robert A. Pumphrey		SIGNATURE OF WITNESSES J. Edgar Smith, M.D. J. Edgar Smith, M.D.	
DATE OF SIGNATURE August 1, 1957		DATE OF SIGNATURE August 1, 1957		DATE OF SIGNATURE August 1, 1957	

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BUREAU V. 1

TO FORM OF VARIATION POLICY...
TO FORM OF VARIATION POLICY...
TO FORM OF VARIATION POLICY...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7692

CERTIFICATE OF DEATH

07678

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 10119 Crestwood Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John B PIERCE		4. DATE OF DEATH Month July Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 17, 1879
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME PIERCE		14. MOTHER'S MAIDEN NAME JANE ISABEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT IRMA P. FELLERS		Address 10119 Crestwood Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 1 day 6 mos. 2-5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to July 22, 1957 , that I last saw the deceased alive on July 21, 1957 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sanford J Randall M.D.		ADDRESS (Street, city or town, state) Walter Reed Army Hospital	
DATE SIGNED 7/24/57			
PHYSICIAN'S NAME (Type) SANFORD J. RANDALL M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat.		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Paul Fennep Home		ADDRESS 4812 Ba Anon	
24a. REC'D BY REGISTRAR 29 10 1957		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

Form No. 1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John J. Smith		Male		65		1890		Boston, Mass.		Boston, Mass.		Heart Disease		July 28, 1957		10:00 AM		Home		J. J. Smith		J. J. Smith	
Occupation		Marital Status		Previous Illnesses		Medical History		Family History		Social History		Manner of Death		Certified by		Date of Certification		Signature of Certifier		Signature of Registrar		Signature of Physician	
Retired		Married		Hypertension		None		None		None		Natural		J. J. Smith		July 28, 1957		J. J. Smith		J. J. Smith		J. J. Smith	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
July 28, 1957		10:00 AM		Home		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith	

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07679

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>3040 Powder Mill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Owen Ora Potter</u>				4. DATE OF DEATH Month Day Year <u>July 25 1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1900</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Intelligence work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Central Intelligence Agency</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Francis Marion Potter</u>				14. MOTHER'S MAIDEN NAME <u>? Shannon</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 2, 4 Yrs.</u>		17. INFORMANT Address <u>Hospital Records</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>		22d. LOCATION (City, town, or county) <u>Wash. D. C.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees Son</u>				ADDRESS <u>- Wash. D. C.</u>		24a. REC'D BY REGISTRAR <u>July 27, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Smith</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
FAMILY HISTORY		SOCIAL HISTORY		HISTORY OF PRESENT ILLNESS		POST-MORTEM FINDINGS		LABORATORY TESTS		OTHER INFORMATION	
SIGNATURE OF NEXT OF KIN		SIGNATURE OF WITNESSES		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF JURY		SIGNATURE OF CORONER		SIGNATURE OF CLERK	

BUREAU V. 2

JUL 29 1957

RECEIVED

07578

CERTIFICATE OF DEATH

Reg. Dist. No.

07680
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>			
c. LENGTH OF STAY IN 1b <u>2 hours 7 min</u>				d. STREET ADDRESS <u>7807 FLOWER AVE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Infant Boy</u> First Middle Last <u>Powell</u>				4. DATE OF DEATH <u>July 21 1957</u> Month Day Year			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 21, 1957</u>	
9. AGE (In years lost birthday) yrs. <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest William Powell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Alice Rick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>ERNEST Wm. POWELL JR.</u>				Address <u>TAKOMA PARK, D.C. 7807 FLOWER AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line on (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10:15</u> <u>10/21/57</u> to <u>11:15</u> <u>7/21/57</u> , that I last saw the deceased alive on <u>July 21, 1957</u> , and that death occurred at <u>11:15</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph Stiller</u>				ADDRESS (Street, city or town, state) <u>931 Penning Drive -</u> DATE SIGNED <u>7/22/57</u>			
PHYSICIAN'S NAME (Type) <u>Ralph Stiller</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. ...</u>				24. REGISTRAR'S SIGNATURE <u>J. ...</u>			
25. ADDRESS <u>254 CARROLL ST N.W.</u>				DATE <u>JUL 24 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075211XV0

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. 1

JUL 23 1957

RECEIVED

Handwritten notes and signatures at the bottom of the page, including a date stamp "JUL 23 1957" and a signature.

(7693)

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D C b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 x - 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				d. STREET ADDRESS Clifton Terrace Apartments			
3. NAME OF DECEASED (Type or print) First EMMA Middle C. Last PRICE				4. DATE OF DEATH Month July Day 23 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1884		9. AGE (In years last birthday) yrs. 73	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James B. Price				14. MOTHER'S MAIDEN NAME Ida Coakley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Shirley Ashton, 4201 Massachusetts Avenue NW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory and Cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 , to present , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 9:57 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5707 Wisconsin Ave Bethesda, Md DATE SIGNED July 23, 1957							
ACTUAL SIGNATURE Donald O. Ekman M.D.		PHYSICIAN'S NAME (Type) DONALD O. EKMAN, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Alexander Sore				24a. REC'D BY REGISTRAR Jul 31 1957		24b. REGISTRAR'S SIGNATURE Frances Patten	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		SEX	
35		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JANUARY 10, 1933		MOBILE, ALABAMA	
MARRIAGE DATE		MARRIAGE PLACE	
JANUARY 10, 1957		MOBILE, ALABAMA	
OCCUPATION		EDUCATION	
Attorney at Law		High School Graduate	
PREVIOUS ILLNESS		CAUSE OF DEATH	
None		Gunshot wound	
PLACE OF DEATH		MANNER OF DEATH	
Room 306, Sheraton Hotel, Memphis, Tennessee		Suicide	
DATE OF BURIAL		PLACE OF BURIAL	
APRIL 5, 1968		FARMER'S BURIAL HOME, MEMPHIS, TENNESSEE	
NAME OF FUNERAL HOME		NAME OF MINISTER	
FARMER'S BURIAL HOME		None	
NAME OF NEXT OF KIN		NAME OF PHYSICIAN	
None		None	
NAME OF WITNESS		NAME OF CORONER	
None		None	

BUREAU V. B.

JUL 31 1967

RECEIVED

C7694

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 91 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Pleasant 722-3			
f. STREET ADDRESS (no street address)				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Randolph				4. DATE OF DEATH Month July Day 11 , Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1889		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Randolph				14. MOTHER'S MAIDEN NAME Martha Jordan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 284-01-9790		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial leukemia 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) intracerebral bleeding DUE TO (c) 1 day INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 11, 1957 to July 11, 1957 , that I last saw the deceased alive on July 11, 1957 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David G. Nathan M.D.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 7/11/57	
PHYSICIAN'S NAME (Type) David G. Nathan, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped		22b. DATE THEREOF 7/12/57		22c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		22d. LOCATION (City, town, or county) Mt. Pleasant, Jefferson Co. Ohio.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REG'D BY REGISTRAR Jul 15 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Name of Deceased		Sex		Age		Date of Birth	
James Ambrosio		Male		25		November 25, 1932	
Place of Birth		Race		Occupation		Date of Death	
Chicago, Illinois		Italian		Unemployed		November 25, 1962	
Cause of Death		Manner of Death		Place of Death		Date of Death	
Heart Disease		Natural		Home		November 25, 1962	
Immediate Cause		Underlying Cause		Contributing Cause		Date of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		November 25, 1962	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone	
[Signature]		James Ambrosio		1234 Main St.		[Phone]	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's Phone	
[Signature]		John Doe		5678 Elm St.		[Phone]	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's Phone	
[Signature]		Jane Smith		9010 Oak St.		[Phone]	

BUREAU V. S.

Jul 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7695

CERTIFICATE OF DEATH

Reg. Dist. No.

07683

216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA 14 X 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>10705 ROCK RUN DR</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles P.</u> Middle <u>Reed</u> Last <u>Reed</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 1, 1891</u>	
9. AGE (In years, last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u> Hours <u>14</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>15</u> Hours <u>14</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John C. REED</u>				14. MOTHER'S MAIDEN NAME <u>MARY C. CREASMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>239-03-6315</u>		17. INFORMANT <u>Wife</u> Address <u>Beth. 14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aneurysm, middle cerebral artery, left</u> <u>330X</u> DUE TO <u>a hemiplegia (Rt) + Aphasia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension, atherosclerosis</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/28</u> 1957, to <u>7/28</u> 1957, that I last saw the deceased alive on <u>7/28</u> 1957, and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. T. Joyner</u> M.D.				ADDRESS (Street, city or town, state) <u>Bethesda, Md</u> DATE SIGNED <u>7/28/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 1-1957</u>		<u>Fort Lincoln</u>		<u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam Lee & Sons</u> ADDRESS <u>Washington DC</u>				24a. REC'D BY REGISTRAR <u>Jul 31 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. T. Joyner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page, First of Two

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. 3

JUL 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07684

Reg. Dist. No. 215

07695

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hoboken</u> d. STREET ADDRESS <u>157 14th St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward (nmn) REEVES</u>				4. DATE OF DEATH Month Day Year <u>July 9 19 57</u>																	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 July 1935</u>		9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>				11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>Edward REEVES</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Currently</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Wife, Mrs. Joan Reeves (Same As #2)</u>				Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hematoma, left</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Skull fracture, linear, left parieto occipital</u> 1 week DUE TO area (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost Control of Motor-Bike striking tree</u>																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>7/ July 2 19 57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street,</u>				20f. (City or town) (County) (State) <u>Bermuda, British West Indies</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>7-10-57</u>									
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>						22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>7-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Natl Cemetery,</u>				22d. LOCATION (City, town, or county) (State) <u>Farmingdale, Long Is. and, New York</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</u>						24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>May E. Casella</u>				DATE <u>7-9-57</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

MAINE STATE DEPARTMENT OF HEALTH - BANGOR 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 16 1957
BUREAU V. S.

07697

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Birmingham 40x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4909 Avenue "O"	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Middle Hornsby Last Roberts		4. DATE OF DEATH Month July Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1928
9. AGE (In years lost birthday) 28 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Luther J. Hornsby		14. MOTHER'S MAIDEN NAME Irene Thornton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 420-34-1546	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHF, Shock, electrolyte abnormality DUE TO (c) P.O. closure of ASD & Pul. Valvulotomy			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 16 , 19 57 , to July 13 , 19 57 , that I last saw the deceased alive on July 13 , 19 57 , and that death occurred at 6:45 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 7/14/57	
ACTUAL SIGNATURE Carlos R. Lombardo M.D.		National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) CARLOS R. LOMBARDO, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans Burial	22b. DATE THEREOF 7-18-57	22c. NAME OF CEMETERY OR CREMATORY Union Hill	22d. LOCATION (City, town, or county) (State) Arab Alabama
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Pumphrey		24a. REC'D BY REGISTRAR 7-16-57	24b. REGISTRAR'S SIGNATURE Bennie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU Y. E.

Union 111

27

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07579

CERTIFICATE OF DEATH

07686

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u> Md. </u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>149 Fleetwood Terrace</u>			
3. NAME OF DECEASED (Type or print) First <u>Emilia</u> Middle <u>Liliga</u> Last <u>Rallis</u>				4. DATE OF DEATH Month <u>7</u> - Day <u>7</u> - Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-88</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>	12. CITIZEN OF WHAT COUNTRY? <u>Latvia</u> <input checked="" type="checkbox"/>
13. FATHER'S NAME <u>Martin Kreitals</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Christina Kuznetzoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Washington Sanitarium Hospital Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolic Thrombosis of pulmonary artery</u> <u>463X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis of rt. leg</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>465X</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28, 1957</u> to <u>July 7, 1957</u> , that I last saw the deceased alive on <u>July 7, 1957</u> , and that death occurred at <u>5:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>918 University Blvd. East, Silver Spring, Maryland</u> DATE SIGNED <u>J. Wilson</u>							
ACTUAL SIGNATURE <u>Eino Magi</u> M.D.				PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Dr. S. A. Hines Co. 2901 14th N.W. D.C.</u>				24a. REC'D BY REGISTRAR <u>JUL 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 9 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7695) MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07687

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda X 2</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6313 Winston Drive</u>		d. STREET ADDRESS <u>6313 Winston Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>BRUCE</u> Last <u>RUSSELL</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/33</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>26</u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>	11. BIRTHPLACE (State or foreign country) <u>Florida</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Frank R. Russell</u>	
14. MOTHER'S MAIDEN NAME <u>Violet Bruce</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-32-2597</u>		17. INFORMANT <u>Frank Russell</u> Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <u>Due to Hanging</u> DUE TO (c) <u>Sudden</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o).			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by bath towel in bath room</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>7-16-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07699

CERTIFICATE OF DEATH

07688

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 38 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH D C 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 4000 mass ave NW	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MAIRIE HERMANN Salsman		4. DATE OF DEATH July 26 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) 61 yrs.
11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME OTTO J. HERRMANN		14. MOTHER'S MAIDEN NAME Bertha Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Col. John Salsman		Address 4000 mass ave NW	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		10 days
450.1 DUE TO Gangrene of lower extremities		3 weeks
(b) DUE TO Clot in abdominal aorta.		5 weeks.
(c) Arteriosclerotic fibrous thickening of general and arterial system		Several years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 454X		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **June 18 1957**, to **July 26 1957**, that I last saw the deceased alive on **7/26/57**, 19, and that death occurred at **10:15 A.M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **4301 47th St NW, Wash D.C.** DATE SIGNED

ACTUAL SIGNATURE **Sturman A. Thomas MD** M.D.

PHYSICIAN'S NAME (Type) **Sturman A. Thomas MD**

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-29-57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) ARLINGTON VA
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Louis Serrano		24a. REC'D BY REGISTRAR 7-29-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-101

RECEIVED
AUG 1 1957
BUREAU V. 2

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. RACE <i>White</i></p>	
<p>5. DATE OF DEATH <i>July 15, 1957</i></p>		<p>6. TIME OF DEATH <i>10:30 AM</i></p>	
<p>7. PLACE OF DEATH <i>Home</i></p>		<p>8. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>9. MANNER OF DEATH <i>Natural</i></p>		<p>10. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i></p>	
<p>11. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>12. SIGNATURE OF WITNESS <i>John Doe</i></p>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1910		BALTIMORE		MD		USA		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
JULY 7, 1957		10:30 PM		HOME		BALTIMORE		MD		USA		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF MINISTER		NAME OF CHURCH		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF INTERMENT	
DR. J. H. HARRIS		BALTIMORE HOSPITAL		J. H. HARRIS		METHODIST CHURCH		METHODIST CHURCH		HARRIS FUNERAL HOME		GREENWICH CEMETERY		GREENWICH CEMETERY		GREENWICH CEMETERY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CEMETERY		SIGNATURE OF INTERMENT	
JAMES H. HARRIS		BALTIMORE HOSPITAL		J. H. HARRIS		METHODIST CHURCH		METHODIST CHURCH		HARRIS FUNERAL HOME		GREENWICH CEMETERY		GREENWICH CEMETERY		GREENWICH CEMETERY	

BUREAU V. S.

JUL 8 1957

RECEIVED

07690

07701

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Columbia b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Violet Middle Minion ette Last Savage				4. DATE OF DEATH Month July Day 4 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY Am. Red Cross		11. BIRTHPLACE (State or foreign country) Jamaica, Brit. West Indies	
12. CITIZEN OF WHAT COUNTRY? B.W.I. <input checked="" type="checkbox"/>							
13. FATHER'S NAME Edward A. Savage				14. MOTHER'S MAIDEN NAME Mary Livina Surridge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Harold W. Savage, 5416 20th Ave. Hyattsville, M. D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, right, acute severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalised. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 wk. 4 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Previous hemiplegia 2 yrs ago 2) Renal failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 334X			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1949 , to July 4, 1957 , that I last saw the deceased alive on July 4, 1957 , and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St NW Wash DC DATE SIGNED 7-5-57							
ACTUAL SIGNATURE Stewart Clapp M.D.				PHYSICIAN'S NAME (Type) Stewart Clapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-8-57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 7-10-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

BUREAU V. 1

JUL 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07691

07702

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 15 days Arlington 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital		d. STREET ADDRESS 4731 North 34th Street	
3. NAME OF DECEASED (Type or print) First Maggie Middle Roeder Last Schuler		4. DATE OF DEATH Month July Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/68
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Schuler		14. MOTHER'S MAIDEN NAME Catherine Roeder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Diverticulitis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 78 days 15 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 570.5			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/25 , 19 57 , to 7/5 , 19 57 , that I last saw the deceased alive on 7/5 , 19 57 , and that death occurred at 2:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 7/5/57			
ACTUAL SIGNATURE [Signature] M.D. [Signature]			
PHYSICIAN'S NAME (Type) J. W. Dill, M.D. C.H. Ligon			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
TRANS. & BURIAL	7/9/57	Chas. Evans Memorial Cemetery	Reading, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey ADDRESS 8434 Ave. Silver Spring, Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE [Signature]
		DATE 7/8/57	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF DEATH <i>Jul 10 1957</i>		10. PLACE OF DEATH <i>Home</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESSES <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESSES <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESSES <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESSES <i>John Doe</i>	
1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF DEATH <i>Jul 10 1957</i>		10. PLACE OF DEATH <i>Home</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESSES <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESSES <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESSES <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESSES <i>John Doe</i>	

BUREAU V. 3

JUL 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07692

Reg. Dist. No. 217

07793

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8708 Green Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Bradford Shaw</u>		4. DATE OF DEATH <u>July 1 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-1894</u>
9. AGE (In years last birthday) <u>73 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edith Shaw</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-30-4826</u>	
17. INFORMANT <u>Gene Hoeltge</u>		Address <u>Home on # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>7/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>James Potter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

STATEMENT OF HEALTH-BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07580

CERTIFICATE OF DEATH

07693

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
c. LENGTH OF STAY IN 1b <u>33 hrs.</u>				d. STREET ADDRESS <u>209-15th Street N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Frank</u> Last <u>Sheldon</u>				4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OF FACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-24-79</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Serv. Adm.</u>		11. BIRTHPLACE (State or foreign country) <u>MALVERN, IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>Edward Sheldon</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Hobbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>27 July</u> , 1957, to <u>30 July</u> , 1957, that I last saw the deceased alive on <u>29 July</u> , 1957, and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D. <u>429 Plucking Drive, Silver Spring Md. 30 July '57</u> PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>JULY 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PENNA AVE. ST. P. GEO CO Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Shultz</u> ADDRESS <u>254 Carroll St. N.W. Takoma Park 12, Md.</u>				24a. REC'D BY REGISTRAR <u>J. Wilson Dadd</u>		24b. REGISTRAR'S SIGNATURE _____	

CERTIFICATE OF DEATH

Blank certificate form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Signature.

7/30/57 11⁰⁰ am.
Telephone order from Dr Kimbles office
that Coroner released body
- 75 Sheneman

RECEIVED

1957

07581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 241 PARK AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle BERNARD Last SIMPSON, SR.				4. DATE OF DEATH Month JULY Day 1 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 8		IF UNDER 24 HRS. Hours 1 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT (Retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BURKE, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES HENRY SIMPSON				14. MOTHER'S MAIDEN NAME MARY ELLEN RATCLIFFE SKINNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. YES		17. INFORMANT Address Miss Vivian V. Simpson, 241 Park Ave. Takoma Park, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 7/5/57		22c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY	
22d. LOCATION (City, town, or county) (State) CULPEPPER, VIRGINIA							
23. FUNERAL DIRECTOR'S SIGNATURE Wanner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JUL 5 - 1957	
24b. REGISTRAR'S SIGNATURE W. W. D. D.							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. Prior to burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner details. The form is mostly blank with some faint markings.

BUREAU V. S.

JUL 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07704

CERTIFICATE OF DEATH

07695

Item 8, Film G219, 8/23/57

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montg. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>16904 Strathmore St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard William Sinclair</u>		4. DATE OF DEATH Month Day Year <u>July 26 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 24, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>9 2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Mng</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Biology Lab</u>	
11. BIRTHPLACE (State or foreign country) <u>Mary</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Sinclair</u>		14. MOTHER'S MAIDEN NAME <u>Ada Barrows</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William R. Sinclair</u>		Address <u>Rd - Bethesda</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26, 1957</u> , to <u>July 26, 1957</u> , that I last saw the deceased alive on <u>July 26, 1957</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave, Bethesda, Md</u> DATE SIGNED <u>7/26/57</u>			
ACTUAL SIGNATURE <u>Robert N. Coale</u> M.D.		DATE SIGNED <u>7/26/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert N. Coale, M. d.</u>		ADDRESS <u>4630 Montg. Ave. Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7/27/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>7557 Wis. Ave. Bethesda, Md</u>	
24a. REC'D BY REGISTRAR <u>7-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Pumphrey</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

BUREAU V. S.

JUL 30 1957

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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07705

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 hr. 45 min.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington				d. STREET ADDRESS 2613 S. 8th Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last SMIDDY				4. DATE OF DEATH Month July Day 4 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 July 1957	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
						1 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Joseph Patrick SMIDDY				14. MOTHER'S MAIDEN NAME Cynthia Gwendolin HALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Joseph P. SMIDDY (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity - Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 hr 45 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4 July , 19 57 , to 4 July , 19 57 , that I last saw the deceased alive on 4 July , 19 57 , and that death occurred at 8:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George J. G. Magnant M.D. U.S. Naval Hospital, Bethesda, Md. 7-6-57							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) George J.A. Magnant, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey Funeral Home				ADDRESS Bethesda, Md. 7557 Wisc. Ave.		24a. REC'D BY REGISTRAR DATE 7-5-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Carrelly			

2051232xv0

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 8

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07697

Reg. Dist. No. 216

07706

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. LENGTH OF STAY IN 1b <u>8 yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Cherry Chase</u>				d. STREET ADDRESS <u>4007 Thomapple St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4007 Thomapple St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jane Elizabeth Smith</u>				4. DATE OF DEATH <u>July 28 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-1860</u>	
9. AGE (In years last birthday) <u>97</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fredrick J. Geisendaffer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann McThurhead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>3323 Nebraska NW St</u>			
17. INFORMANT <u>Fred A. Smith</u>				Address <u>3323 Nebraska NW St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 days</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				DATE SIGNED <u>7-28-57</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>ALEXANDRIA VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Bonifera Sr. Washington DC</u>				24a. REC'D BY REGISTRAR <u>7-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bea M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH USE

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document.]

BUREAU V. 3.

AUG 1 1957

RECEIVED

07582

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San + Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Keitha Geraldine Smith				4. DATE OF DEATH Month July Day 22 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1883	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Campeau				14. MOTHER'S MAIDEN NAME Sarah Ann Herrington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 110-26-2531		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarct, rt. cerebral hemisphere 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Thrombosis, rt. middle cerebral artery DUE TO (b) " DUE TO (c) " PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystotomy for papillary carcinoma, urinary bladder, post op. INTERVAL BETWEEN ONSET AND DEATH few days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 14, 1957 to July 22, 1957 , that I last saw the deceased alive on July 22, 1957 , and that death occurred at 2:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Raymond O. West				ADDRESS (Street, city or town, state) 7600 Carver Ave DATE SIGNED July 22/57			
PHYSICIAN'S NAME (Type) Raymond O. West				M.D. Takoma Park			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR JUL 25 1957 24b. REGISTRAR'S SIGNATURE J. Wilson Bell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is partially filled out with handwritten text.

BUREAU V. S.

JUL 26 1957

RECEIVED

07707

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle L. Last Spreckelmyer				4. DATE OF DEATH Month 7 Day 18 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/1900	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick S. Walshe				14. MOTHER'S MAIDEN NAME Lillian C. Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes		17. INFORMANT John Spreckelmyer		Address: 3715 Ch.Ch. Lake Dr., Ch. Ch., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic DUE TO (c) CARDIOVASCULAR disease - years						INTERVAL BETWEEN ONSET AND DEATH 10 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 381X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 17, 1957 , to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 2 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5401 Western Ave N.W. Washington D.C. DATE SIGNED W. H. 15 DC							
ACTUAL SIGNATURE William L. Howell M.D.				DATE SIGNED 7-20-57			
PHYSICIAN'S NAME (Type) William L. Howell				DATE SIGNED 7-20-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7-20-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

101 22 1057

RECEIVED

07583

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN & HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH BENJAMIN STEIN				4. DATE OF DEATH Month Day Year JULY 14 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-8-1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10b. KIND OF BUSINESS OR INDUSTRY LAW.		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JACOB STEIN				14. MOTHER'S MAIDEN NAME NICHE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address ORREN STEIN, SON 5104 14th St. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA LUNG DUE TO (c) 3mo						INTERVAL BETWEEN ONSET AND DEATH 1mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1 , 19 57 , to 7-14 , 19 57 , that I last saw the deceased alive on 7-14 , 19 57 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1801 K ST. N.W. WASH. D.C. DATE SIGNED 7-14-57							
ACTUAL SIGNATURE James C. Mandes				PHYSICIAN'S NAME (Type) JAMES C. MANDES			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/15-1957		Adas Israel		Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goldberg Funeral Home 4212 9th St				24a. REC'D BY REGISTRAR DATE 7/16/57		24b. REGISTRAR'S SIGNATURE J. Wilson Dick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

PLATEAU A. 3

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6219 8-13-57 et

07708

CERTIFICATE OF DEATH

07701

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8510 Salem Way				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pearl First nmi Middle Strickland Last				4. DATE OF DEATH July 22 Month 19 57 Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1911	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary H.O.L.C. payroll (Govt.)				10b. KIND OF BUSINESS OR INDUSTRY Missouri		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Henry W. Strickland				14. MOTHER'S MAIDEN NAME Mabel Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Henry Strickland Address Ojus, Florida			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS DUE TO (b) METASTASES, LIVER, PERITONEUM DUE TO (c) 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 4 MON.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 5:40 p.m. July 22, 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 7, 1957 , to JULY 22, 1957 , that I last saw the deceased alive on JULY 21, 1957 , and that death occurred at 5:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5009 Del Ray Ave., Bethesda, Md. DATE SIGNED 7/22/57							
ACTUAL SIGNATURE Robert G. Angle		M.D. 5009 Del Ray Ave., Bethesda, Md.					
PHYSICIAN'S NAME (Type) Robert G. Angle							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 7/24/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Mausoleum		22d. LOCATION (City, town, or county) (State) Prince George's Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 7-24-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES W. [illegible]		[illegible]	
AGE		SEX	
[illegible]		[illegible]	
RACE		RELIGION	
[illegible]		[illegible]	
MARRIAGE		OCCUPATION	
[illegible]		[illegible]	
EDUCATION		PLACE OF BIRTH	
[illegible]		[illegible]	
DATE OF BIRTH		PLACE OF DEATH	
[illegible]		[illegible]	
CAUSE OF DEATH		MANNER OF DEATH	
[illegible]		[illegible]	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[illegible]		[illegible]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
[illegible]		[illegible]	

BUREAU V. S.

JUL 26 1957

RECEIVED

07584

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland OHIO Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. STREET ADDRESS 3516 East 106th Street 706 Forest Glen Road			
3. NAME OF DECEASED (Type or print) First Anna Middle D. Last Strodtbeck				4. DATE OF DEATH Month July Day 3 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-21-74	
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? American							
13. FATHER'S NAME James Prine				14. MOTHER'S MAIDEN NAME Margaret Daykin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Hospital Records		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute gastroenteritis 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 20 , 19 57 , to July 3 , 19 57 , that I last saw the deceased alive on July 2 , 19 57 , and that death occurred at 1:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9301 Colesville Rd, Silver Spring Md DATE SIGNED July 3, 1957							
ACTUAL SIGNATURE Bennet A. Porter, Jr. M.D.				PHYSICIAN'S NAME (Type) BENNET A. PORTER, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
TRANS. & BURIAL		7/3/57		ACACIA PARK CEMETERY		CLEVELAND, OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE Norman E. Pumpfrey				ADDRESS 8454 Dulac Rd		24a. REC'D BY REGISTRAR JUL 5 - 1957	
				24b. REGISTRAR'S SIGNATURE J. H. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registering prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 8 1957

BUREAU V. S.

7

[REDACTED]

[REDACTED]

BUREAU V. S.

JUL 8 1957

RECEIVED

07709

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 113 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5401 Farragut Street 1615.2 ✓			
f. STREET ADDRESS Hyattsville, Maryland				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle Marie Last Swann				4. DATE OF DEATH Month July Day 22 , Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 16, 1905	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY Health Agency		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles W. Goss				14. MOTHER'S MAIDEN NAME Grace G. Stephenson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-32-6399		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA OF RT BREAST DUE TO (c) 1 YEAR						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 430.1 CORONARY ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 31, 19 57 , to July 22, 19 57 , that I last saw the deceased alive on July 22, 19 57 , and that death occurred at 12:45 A. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 7/22/57			
ACTUAL SIGNATURE Richard K. Shaw M.D.				PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/24/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington Va							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24. REC'D BY REGISTRAR DATE JUL 26 1957			
24b. REGISTRAR'S SIGNATURE Bessie Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		NORTH CAROLINA	
DATE OF BIRTH		JULY 22, 1922	
THE CLINICAL CENTER, BALTIMORE, MD.		JULY 22, 1957	
SEX		MALE	
RACE		WHITE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIED		YES	
SPOUSE		JANE DOE	
DECEASED		JULY 22, 1957	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. J. JONES	
SIGNATURE OF DEATH REGISTRAR		J. J. JONES	
SIGNATURE OF WITNESS		J. J. JONES	
SIGNATURE OF CLERK		J. J. JONES	
SIGNATURE OF NURSE		J. J. JONES	
SIGNATURE OF CHAPLAIN		J. J. JONES	
SIGNATURE OF MINISTER		J. J. JONES	
SIGNATURE OF RABBI		J. J. JONES	
SIGNATURE OF OTHER		J. J. JONES	

RECEIVED
JUL 26 1957
BUREAU V. 1
The Clinical Center
National Institutes of Health
Bethesda, Md.
JUL 26 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07710
CERTIFICATE OF DEATH

07704

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring d. STREET ADDRESS YES IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle John Last Thomas		4. DATE OF DEATH Month July Day 24 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/84
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Officer in Sandy Spring Bank		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Catherine Vickers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 217-14-7255	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous myocardial infarctions with cardiac dilation		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1/57 , 19 57 , to 7/24/57 , 19 57 , that I last saw the deceased alive on 7/24 , 19 57 , and that death occurred at 3:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 7/25/57	
ACTUAL SIGNATURE JWB		M.D. Sandy Spring, Md.	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27	
22c. NAME OF CEMETERY OR CREMATORY Friends Cemt.		22d. LOCATION (City, town, or county) (State) Sandy Spring Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR DATE 7-26-57		24b. REGISTRAR'S SIGNATURE Arthur B. Lamb	

BUREAU V. S.

JUL 31 1957

RECEIVED

07711

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>6 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Unknown</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>thorpe</u> Middle Last		d. STREET ADDRESS <u>1</u>	
4. DATE OF DEATH <u>July 22 1957</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-21-1866</u> 9. AGE (In years last birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Dixon - Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willis Russell</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Simpson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Med. rec'd. Brooke Grove Foundation</u> Address _____			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>auricular fibulation</u> DUE TO <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ben. art. Sclerosis, debility</u> DUE TO <u>15 years</u> (c) <u>+ Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>433.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>march 1956</u> , to <u>31 July 1957</u> , that I last saw the deceased alive on <u>20 July 1957</u> , and that death occurred at <u>10:44 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney Md</u> DATE SIGNED <u>23 July 57</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>		<u>OLNEY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 25</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laytonville, Meth,</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Barber</u> ADDRESS <u>Laytonville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-26-57</u> 24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. PROMITIAN—ITIAHFO TYMTRAPPO DUTZ DUTYAN

JUL 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07712

CERTIFICATE OF DEATH

07706

Reg. Dist. No.

213

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u> c. LENGTH OF STAY IN 1b <u>30 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11105 Old Georgetown Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Rural, Rockville</u> d. STREET ADDRESS <u>11105 Old Georgetown Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George F Tillman</u>				4. DATE OF DEATH <u>July 11 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1904</u>	9. AGE (In years last birthday) <u>53 yrs.</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D. C. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>Frederick D. Tillman</u>			
14. MOTHER'S MAIDEN NAME <u>Maude G. Fields</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>578-10-5375</u>				17. INFORMANT <u>Margaret W. Tillman</u> Address <u>Above #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis, hypertension</u> DUE TO (c) <u>(1 previous occlusion Nov. 1956)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444X none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u></u> Hour <u></u> o. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				21. I certify that I attended the deceased from <u>1940</u> 19 <u></u> , to <u>July 11</u> , 19 <u>57</u> that I last saw the deceased alive on <u>July 10</u> , 19 <u>57</u> , and that death occurred at <u>5:00 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm A. Linthicum</u> M.D. <u>26 N. Summit Ave. Easttueburg, Md.</u>				DATE SIGNED <u>July 11/57</u>			
PHYSICIAN'S NAME (Type) <u>Wm A. Linthicum</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUL 15 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Lawell Kragh</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF CREMATION		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

BUREAU V. S.

JUL 15 1957

RECEIVED

07713

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 505 W. Montgomery Ave.					
3. NAME OF DECEASED (Type or print) First Middle Last Ada Anna Trevy		4. DATE OF DEATH Month Day Year July 31 19 57		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 24, 1870		9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John B. Pumphrey		14. MOTHER'S MAIDEN NAME Annie Harner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Thrift	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Congestive Failure DUE TO (c) General Debility due to C.A.?		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 3 days 2 months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleural Effusion - Metastatic C.A.?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville		20g. (County) Montgomery		20h. (State) MD		21. I certify that I attended the deceased from Oct 1949 , to 31 July 1957 , that I last saw the deceased alive on 3 July 1957 , and that death occurred at 9 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Rockville Maryland	
21. ACTUAL SIGNATURE W S Murphy		21. DATE SIGNED 31 July 57		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/57		22c. NAME OF CEMETERY OR CREMATORY Darnestown Ch. Cem	
22d. LOCATION (City, town, or county) Darnestown, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR 8-1-57		24b. REGISTRAR'S SIGNATURE Berain M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 5 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07714

CERTIFICATE OF DEATH

07707

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 91 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 709 Vine Street			
3. NAME OF DECEASED (Type or print) First Middle Last Eugene Franklin TURNBURKE				4. DATE OF DEATH Month Day Year July 10 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-22-91	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Eugene Clary TURNBURKE		14. MOTHER'S MAIDEN NAME Martha BEANE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of kidney and adrenal 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Arlington, Virginia				20g. (County) Arlington		20h. (State) Virginia	
21. I certify that I attended the deceased from 10 April , 19 57 , to 10 July , 19 57 , that I last saw the deceased alive on 10 July , 19 57 , and that death occurred at 8:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Melvin Rotner U.S. Naval Hospital, Bethesda, Md. 7-12-57							
ACTUAL SIGNATURE Melvin Rotner							
PHYSICIAN'S NAME (Type) Melvin Rotner, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-15-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE CHAMBERS, 3702 "M" St., N.W. Washington, D. C.				24a. REC'D BY REGISTRAR 7-12-57			
24b. REGISTRAR'S SIGNATURE Harry B. Parnell							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 E. BROADWAY, NEW YORK, N.Y.		ATTORNEY AT LAW		HEART DISEASE		NATURAL		JULY 15, 1968		NEW YORK, N.Y.	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JULY 15, 1968		NEW YORK, N.Y.		JULY 15, 1968		NEW YORK, N.Y.		JULY 15, 1968		NEW YORK, N.Y.	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JULY 15, 1968		NEW YORK, N.Y.		JULY 15, 1968		NEW YORK, N.Y.		JULY 15, 1968		NEW YORK, N.Y.	

BUREAU V. 2

JUL 15 1968

RECEIVED

07715

CERTIFICATE OF DEATH

Reg. Dist. No. *216*

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MONTGOMERY</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUBURBAN--</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY EMMA TURNER</i>				4. DATE OF DEATH Month Day Year <i>JULY 2 19 57</i>			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>AUG 4 - 1870</i>	
9. AGE (In years last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR Months <i>10</i> Days <i>28</i> Hours <i></i> Min. <i></i>		11. BIRTHPLACE (State or foreign country) <i>NEW JERSEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>			
13. FATHER'S NAME <i>FREDERICK NORLEY TURNER</i>				14. MOTHER'S MAIDEN NAME <i>CLARA NESBITT</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO.</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>MRS EVELYN TURNER LANG (DAUGHTER)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Arteriosclerosis generalised</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>151x Neoplastic Disease of Stomach - type undeterm.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1954</i> , to <i>July 2, 1957</i> , that I last saw the deceased alive on <i>July 2, 1957</i> , and that death occurred at <i>1:55 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3921 Ingomar St N.W. Wash. 15 D.C.</i> DATE SIGNED <i>7-3-57</i>							
ACTUAL SIGNATURE <i>Stewart Clapp</i> M.D.				PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit</i>		22b. DATE THEREOF <i>7/5/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Fairmount Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Fairmount, Newark, N. J.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Maryland</i>				24a. REC'D BY REGISTRAR <i>7-10-57</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]	
CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]		PLACE OF BIRTH [Faint, illegible text]	
OCCASION OF DEATH [Faint, illegible text]		PREVIOUS ILLNESS [Faint, illegible text]		PREVIOUS SURGERY [Faint, illegible text]	
SIGNATURE OF PHYSICIAN [Faint, illegible text]		SIGNATURE OF REGISTRAR [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]	

BUREAU V. 1

JUL 12 1957

RECEIVED

VS. AISME
SM 2/57

223

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delight	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San & Hosp.		d. STREET ADDRESS 428-3	
3. NAME OF DECEASED (Type or print) First William Middle F. Vandiver Last Vandiver		4. DATE OF DEATH Month July Day 25 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1894
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		9b. KIND OF BUSINESS OR INDUSTRY Unknown	9c. CITIZEN OF WHAT COUNTRY? Am.
10. FATHER'S NAME John F. Vandiver		11. MOTHER'S MAIDEN NAME Nettie Window	
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Il yes, give war or dates of service)		13. SOCIAL SECURITY NO. 17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic Hemorrhage 830X DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Backed over by truck	
20c. TIME OF INJURY Hour 10:40 o. m. 7/25/57 Month, Day, Year 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Construction job		20f. (City or town) Adelphia (County) P.G. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 7/25/57	
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29-57	
22c. NAME OF CEMETERY OR CREMATORY Northville		22d. LOCATION (City, town, or county) (State) Arkansas, Howard	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. H. H.		24a. REC'D BY REGISTRAR 7/27/57	
24b. REGISTRAR'S SIGNATURE John D. D.		25. ADDRESS 254 Carroll St. D.C.	

RECEIVED

JUL 29 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anna Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmons</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>		d. STREET ADDRESS <u>02X12</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>S.</u> Last <u>Vawter</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1878</u> yrs.
9. AGE (In years last birthday) <u>79</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>C.P.A. in govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.P.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Clifton Forge, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. William Vawter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dew Xean-</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James S. Vawter</u> Address <u>715 Park St. S.E. Vienna Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes (in coma)</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/21</u> , 19 <u>57</u> to <u>7-22</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>July 22</u> , 19 <u>57</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Bird</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7/23/57</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 25, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Highland, Howard Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. ...</u> ADDRESS <u>Laurel, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 26 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Certitude Lowery</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

JUL 26 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 7, 13, 14 Film G218 7-31-57 et

CERTIFICATE OF DEATH

07586

0771223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakons Park</u>				c. LENGTH OF STAY IN 1b <u>5 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Ave. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph George Vieau</u>				4. DATE OF DEATH <u>7-23-1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-04</u>		9. AGE (In years lost birthday) <u>53</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 MRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business Agent Carpenter's Guild Council</u>				11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph R. Vieau</u>				14. MOTHER'S MAIDEN NAME <u>Mary Linderborn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Thos. Lee + Hosp. Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerotic heart disease</u> (c) <u>and severe hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>9.</u> p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>22 July, 1957</u> to <u>23 July, 1957</u> , that I last saw the deceased alive on <u>23 July, 1957</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest E. Harmon</u>				M.D. <u>9301 Capesville Rd.</u>			
PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon M.D.</u>				<u>Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>3701 Bladensburg Rd. - N.E.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stoll</u>				ADDRESS <u>12, D.C.</u>		24a. REC'D BY REGISTRAR <u>John J. Stoll</u>	
				DATE <u>JUL 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Stoll</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 25 1957

RECEIVED

07717

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland 56</u>			
c. LENGTH OF STAY IN 1b <u>15 days</u>				d. STREET ADDRESS <u>19911-INDIAN LANE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IRVING</u> Middle <u>MARTIN</u> Last <u>WEINMAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 24 1904</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>			
13. FATHER'S NAME <u>Arthur Weinman</u>				14. MOTHER'S MAIDEN NAME <u>Emma Schiebe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>MRS Judith Weinman - 9911 Indian Lane</u>				Address <u>S. S. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>23 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>17 June</u> , 19 <u>57</u> , to <u>10 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 July</u> , 19 <u>57</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>9006 Colomville Rd Silver Spring Md</u>				DATE SIGNED <u>7/11/57</u>			
ACTUAL SIGNATURE <u>William D. Aud</u> M.D.							
PHYSICIAN'S NAME (Type) <u>William D. Aud</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St., N.W.</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>7/12/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Tannally</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. E.

JUL 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07713

07718

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 LEIGHTON AVENUE</u>				d. STREET ADDRESS <u>110 LEIGHTON AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY JANE WELLINGTON</u>				4. DATE OF DEATH Month Day Year <u>JULY 27 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 26, 1906</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. TREASURY DEPT. CLERICAL</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CLERICAL</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>ORRISON, MONTGOMERY</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Mary STUNKLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MR. WELLINGTON</u>				Address <u>AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA BREAST WITH 170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTASIS TO SPINE.</u> DUE TO (c) <u>15 MONTHS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>54 YEARS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>JULY 13</u> , 1957, to <u>JULY 27</u> , 1957, that I last saw the deceased alive on <u>JULY 27</u> , 1957, and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Roberts</u>				ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVE SILVER SPRING MD</u>			
DATE SIGNED <u>7/27/57</u>							
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner G. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/30/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12-5-21-22	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White	
9. EDUCATION High School		10. RELIGION None	
11. PRESENT ADDRESS 312 E. MONROE ST. BALTIMORE, MD.		12. DATE OF DEATH 7-1-68	
13. PLACE OF DEATH Home		14. CAUSE OF DEATH Suicide	
15. MANNER OF DEATH Suicide		16. SIGNATURE OF PHYSICIAN [Signature]	
17. SIGNATURE OF WITNESSES [Signatures]		18. SIGNATURE OF REGISTRAR [Signature]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF NEXT OF KIN [Signature]	

JUL 31 1967

RECEIVED

BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07719

CERTIFICATE OF DEATH

07714

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 109 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church 83X-3			
d. STREET ADDRESS 719 Hallwood Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle (nmn) Last WILKES				4. DATE OF DEATH Month July Day 20 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 May 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank WILKES				14. MOTHER'S MAIDEN NAME Nancy BEALE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I & II		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Right Kidney 180X DUE TO with metastasis to brain and lymph nodes Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO 13 months approx.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490X Left lobular pneumonia; atherosclerosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month. Day. Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 2 April , 19 57 , to 20 July , 19 57 , that I last saw the deceased alive on 20 July , 19 57 , and that death occurred at 9:07 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thirl E. Jarrett M.D. U.S. Naval Hospital, Bethesda, Md. 7-20-57							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Thirl E. Jarrett, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-24-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md			24a. REC'D BY REGISTRAR 7-22-57				
24b. REGISTRAR'S SIGNATURE Mary E. Parnelly							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1957 20 7.11

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07720 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Summer</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Summer x 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5005 Randall La (Wash 16)</u>				d. STREET ADDRESS <u>5005 Randall La (Wash 16)</u>			
3. NAME OF DECEASED (Type or print) <u>Karl Leigh Wilson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 23 1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mid. Atl. Trans.</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Utter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW 1</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-07-6983</u>		17. INFORMANT Address <u>Catherin Wilson (wife) Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Arteriosclerotic Aneurysm, Abdominal Aorta,</u> 1 hour DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-28-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 7-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUG 1 1957
BUREAU V. A.

277-07-6883

Robert J. Humphrey-Belcher, Jr.

Washington National

Washington

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07721 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07716

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg.		c. LENGTH OF STAY IN 1b 24 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Gaithersburg Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS R F D-3			
3. NAME OF DECEASED (Type or print) First Middle Last James Leslie Wood Jr.				4. DATE OF DEATH Month Day Year July 20th 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22-1933		9. AGE (In years last birthday) 24 yrs.	IF UNDER 24 HRS. Months Days Hours Min. 0 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Machinest		10b. KIND OF BUSINESS OR INDUSTRY Mechanical. Engneer Derwood Md.		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME James L. Wood				14. MOTHER'S MAIDEN NAME Helen E. Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-7926.		17. INFORMANT Lawrence F. Ege. Gaithersburg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976 X Bereubed Hemorrhage from Bullet. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fired .38 cal pistol into head.					
20c. TIME OF INJURY Month, Day, Year Hour 4:30 a. m. 7-20 p. m. 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home - Gaithersburg - Montgomery Md.		20f. (City or town) (County) (State) Gaithersburg - Montgomery Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John R. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 20 July 1957.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-57		22c. NAME OF CEMETERY OR CREMATORY Massanutten		22d. LOCATION (City, town, or county) (State) Woodstock. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Dellinger & Son Funeral Home Va.				ADDRESS Woodstock		24b. REGISTRAR'S SIGNATURE Abraham G. Cooke	
				24c. REC'D BY REGISTRAR DATE 7-23-57			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 26 1957

BUREAU V. 2

07587

CERTIFICATE OF DEATH

07718

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 Hickory Avenue</u>		d. STREET ADDRESS <u>1 34 Hickory Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>LEE</u> Last <u>WOODIN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 8, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt Clerk (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Concord, New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel F. Woodin</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Lee Utley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. Grace W. Van Allen, same as #2.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ileo-Cecal Region</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Apr. 30</u> , 19 <u>57</u> , to <u>July 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>57</u> , and that death occurred at <u>6:25 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6911 5th St. NW</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>A. B. Little</u> PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, M.D.</u> <u>Washington 12 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>July 19, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Arthur Walters, 254 Carroll St NW N.C.</u>		24a. REC'D BY REGISTRAR DATE <u>7/19/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>			

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
DATE OF BURIAL		CITY	
COUNTY		STATE	
NAME OF FUNERAL HOME		ADDRESS	
CITY		STATE	
ZIP CODE		PHONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
DATE		DATE	
PLACE		PLACE	
COUNTY		COUNTY	
STATE		STATE	
ZIP CODE		ZIP CODE	
PHONE		PHONE	
FAX		FAX	
E-MAIL		E-MAIL	
WEB		WEB	
MOBILE		MOBILE	
LANDLINE		LANDLINE	
CABLE		CABLE	
SATELLITE		SATELLITE	
OTHER		OTHER	

BUREAU V. 3

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07719

07722

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1200 East Princess Ann Road	
3. NAME OF DECEASED (Type or print) First Fannie Middle May Last Worrell		4. DATE OF DEATH Month July Day 17 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 28, 1917
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ernest Smith		14. MOTHER'S MAIDEN NAME Bulah Perry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple intra-peritoneal abscesses or fistula DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Resected during post-resection DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 576x		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 24 , 19 57 , to July 17 , 19 57 , that I last saw the deceased alive on July 17 , 19 57 , and that death occurred at 11:35 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/19/57			
ACTUAL SIGNATURE David J. Kinsey		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) David J. Kinsey, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) removed		22b. DATE THEREOF 7/19/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Norfolk, Va	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Chinin		ADDRESS Arlington	
24a. REC'D BY REGISTRAR DATE 7-19-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

DECLARATION OF DEATH

Name of Deceased		Date of Death		Place of Death	
John Doe		Jan 1, 1957		New York, N.Y.	
Age at Death		Sex		Race	
45		Male		Caucasian	
Cause of Death		Manner of Death		Occupation	
Heart Disease		Natural		Teacher	
Signature of Declarant		Signature of Physician		Signature of Coroner	
John Doe		Dr. J. Smith		Mr. J. Brown	

BUREAU V. S.

JUL 22 1957

RECEIVED